

St. Bartholomew's Hospital



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NOTICE.

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The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., at the Hospital.

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St. Bartholomew's Hospital Journal,
JANUARY 14th, 1896.

"Æquam memento rebus in arduis
Servare mentem."—Horace, Book ii, Ode iii.

To Old Bart.'s Men.

NOTHING, it is said, succeeds like success, but few projects enjoy so great a success as that which has attended the publication of a ST. BARTHOLOMEW'S HOSPITAL JOURNAL. Started nearly two and a half years ago, in the face, we regret to say, of considerable opposition, its circulation has increased steadily and uniformly from the commencement, and we now feel amply justified in predicting that so long as there is a medical school at Bart.'s, so long will there be an "official organ" of the students of that institution.

As has been often stated, one of the main objects put forward by those who first set the infant JOURNAL on its feet was the bringing of old Bart.'s men into a closer relation,

not only with each other, but also with their old school. It was felt that famous as Bart.'s men were for their affection for their Alma Mater, there were yet many men in distant parts of the country, and out of England, who could seldom revisit their school, and whose sources of information, as regards the doings either of their contemporaries or of their successors at St. Bartholomew's, were few indeed. To these it was believed the JOURNAL would serve as a constant channel for welcome news.

The first number of the JOURNAL, published in October, 1893, was sent to every old Bart.'s man whose name was in the Directory. The result, though encouraging, did not represent so great a percentage of old Bart.'s men as had previously been hoped for, and in consequence it was decided to repeat the process with the thirteenth number of the JOURNAL, published in October, 1894. On this occasion there was a most gratifying increase in names of old Bart.'s men on the subscribers' list,—so gratifying, indeed, that the advisability of making another effort at a later date in order to add as many as possible of the remaining names to our list was at once decided upon.

The Finance Committee of the Amalgamated Clubs has chosen the present issue for the occasion, and accordingly this number will be sent to every Bart.'s man whose name can be found in the Directory.

Should our attempt meet with anything like our previous success, we do not doubt but that it will be long ere it again becomes necessary to remind Bart.'s men of the existence of the JOURNAL.

We have, however, in sending out this number a further object than the increase in our subscribers' list. We are particularly anxious to supply our readers with more news of old Bart.'s men. We hesitate to again formulate so old and oft-repeated a request. Surely it is no great thing that we ask, merely that a man on getting an appointment or doing anything that is likely to prove of interest to the friends of his student days, will write a note of the same upon a post-card and address it to the Editor. Perhaps modesty is our opponent in this endeavour; if so, we cannot but express the opinion that such modesty smacks of the

"pride that apes humility," and for the sake of those who do not agree with our opinion we will add that editorial secrets are carefully recognised as such. Even the Publication Committee do not enjoy a knowledge of our sources of information, still less could they translate the *noms de plume* in our Correspondence column. Several old Bart.'s men are kind enough week by week to keep their eyes and ears open, and to send us during the first week of the month various items of news which they consider likely to prove interesting to readers of the JOURNAL. It is to these men that we are indebted for many of the notices of Births, Deaths, Marriages, and Appointments, and to them we tender our sincere thanks for the trouble they take.

On the other hand, it is a matter of common occurrence for us to receive grumbling letters from men whose names appear with some slight inaccuracy in the qualifications. These men have their own laziness to thank. Such errors would never occur if they themselves sent us an accurate notice.

For the sake of those who may still be ignorant of the exact state of affairs, it may perhaps be as well to dip into history and explain the footing on which the JOURNAL stands. Since October, 1892, the various athletic clubs of the Hospital have been amalgamated financially, under the title of "The Amalgamated Clubs," and this body has in turn been amalgamated with the Abernethian Society, so that the present correct designation of the body is "The Amalgamated Clubs and Abernethian Society." The finances of the Amalgamation are controlled by a Finance Committee composed of representatives from the various constituent bodies. The JOURNAL is the property and official organ of the Amalgamation and is under the control of the Finance Committee. An endeavour is made each month to report the doings of the Clubs and of the Abernethian Society, together with a certain amount of clinical news of the Hospital. From time to time papers are contributed by members of the staff, while clinical lectures appear at intervals. The "Notes" column is intended to contain items of general interest to either present or past Bart.'s men.

Efforts are at the present time being made to establish a "Pathological Department," in which pathological examinations will be made at a fixed scale of charges, for the benefit of readers of the JOURNAL. It is hoped that these arrangements will shortly reach completion.

In conclusion, we would direct the attention of old Bart.'s men to the slips enclosed with this number relating to the engravings of the portrait of our late steward, Mr. Mark Morris, by Oules. Already a considerable number of names have been sent in. Those who wish for copies of the engraving should send back the slips without delay.

THE continuation of Mr. Langdon Brown's Abernethian Society paper on the "Mechanism of Phagocytosis" is, we regret to say, crowded out of this number, but will appear in the next issue.

A Fading Record: Early Observations on the Ray Fungus by Mr. Thomas Smith, F.R.C.S.

By A. A. KANTHACK, M.D., M.R.C.P.

IN 1845 B. von Langenbeck, the great German surgeon, while examining some morbid tissues microscopically, discovered curious, star-shaped bodies which he was unable to explain, nor could compare to anything else at that time known to him. It was not till 1878 that the nature and meaning of this discovery was made clear. Then James Israel* of Berlin published his first account on the ray fungus which he found in the tissues of a man who apparently had suffered from pyæmia. Langenbeck, not understanding what he saw, had not made his observations known, but he allowed Israel to publish the drawings which he had made for his own information and instruction in 1845. Since Israel's paper, actinomycosis, the disease produced by the ray fungus, has been recognised as a by no means uncommon affection, and further it has been shown that formerly what was actually actinomycosis had been frequently diagnosed and included under tuberculosis or sarcoma. Thus in our own Museum, under "Diseases of the Liver," there is a specimen (No. 2239c) which in the catalogue was described as tuberculosis until I examined it at Mr. Edgar Willett's request, and proved it to be undoubted actinomycosis. In the animal the ray fungus had been recognised by Bollinger† in 1877; and curiously enough the Indian surgeons, so much maligned in certain quarters for their want of learning and scientific enthusiasm, saw in the Indian fungus disease, or mycetoma—also called Madura disease—a lesion not sarcomatous nor tuberculous in nature. This was in 1860; in 1886 Vandyke Carter suggested that some forms of mycetoma are produced by a fungus resembling the actinomycetes in nature. That the yellow variety of mycetoma is actually caused by a form of actinomycetes or ray fungus was proved by me in 1892.‡

I now wish to record an unknown page in the history of actinomycosis, discovered by Mr. Rudolf Smith among some papers belonging to his father, our senior surgeon. It is a faded sheet of note-paper, covered with neat writing and pencil drawings, both of which show distinct traces of old age. The date of this paper is about 1855. Mr. Smith was then examining the tissues of some interesting and obscure case for Sir James Paget (then Mr. Paget), whose assistant he was. Messrs. C. H. Cosens and E. W. Roughton have kindly photographed the page with the drawings, which is here reproduced. Mr. Smith's own words read as follows:

"Whitish colour slightly tinged with yellow—breaks up easily, no fluid can be pressed out. A section under a low

* *Virchow's Archiv*, lxxiv, 1878.

† *Centralbl. f. d. med. Wiss.*, 1877, No. 27.

‡ *Journal of Path. and Bact.*, vol. i.

power looks like an — colloid, only that the interspaces are not so uniformly ovoid. *The cells?* the more they are magnified the less like cells do they become—and the more evident does the fibrous element show itself. Under a $\frac{1}{4}$ and when together the cells look a little like (starch granules), but have radiating lines running from their circumferences—they are faintly yellow—it is almost impossible to separate them from one another, they seem to break up into fibrous tissue and smaller cells, referred to below, if finely dissected. They are apparently spheroidal, and are matted with each other and with the fibrous tissue. There are as well abundant smaller cells like irregular glandular epithelium.

"The tumour contains a large quantity of imperfectly formed bone mixed up with the proper structure, it creaks when cut with the knife as if the blade were passing between osseous granules. I have seen just the same appearance in ossifying fibrous tissue as is generally presented in this growth, though of course have never met with glandular epithelium cells in the former, but the shining and apparently spheroidal radiated cells and the fibrous tissue arranged as in colloid I have seen either in periosteum or in a kitten's cranial bones."

The next page is faithfully reproduced in the accompanying figure, and it we must study more carefully now. It is evident that Mr. Smith had a case of actinomycosis before him which completely baffled him. In the lower right hand corner of the drawing we find very good representations (under the high power) of the ray fungus, the fringed periphery where the clubs are, and the central granular mycelium. They are correctly described as "yellow," and equally correctly Mr. Smith writes "not cells," for of course they are not cells. "Very difficult to separate,"—this also is true, but I cannot understand what tempted Mr. Smith to say that "when seen in number not unlike ossifying fibrous tissue," as is written below the excellent drawings of the fungus. I dare say Mr. Smith himself can hardly understand this now, even if he could

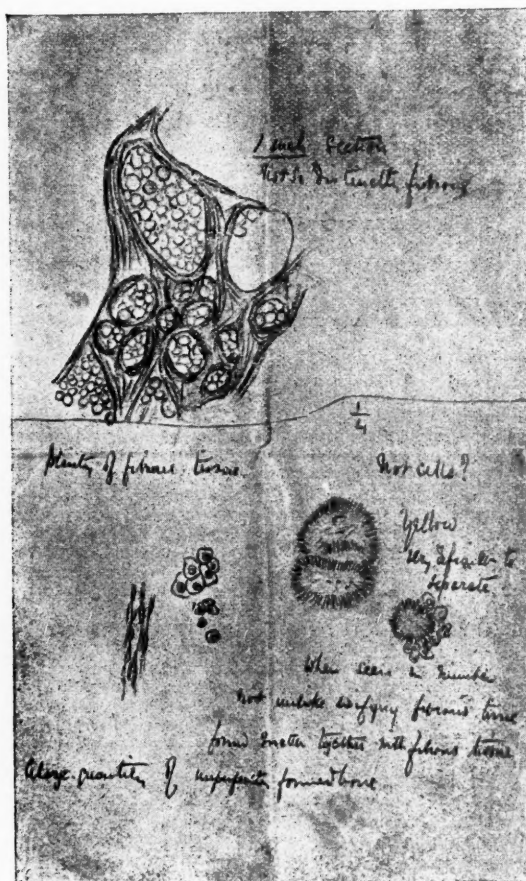
then. He further says, rightly, that the masses were "found matted together with fibrous tissue," and that there was "a large quantity of imperfectly formed bone." The "glandular epithelium cells" are undoubtedly the epithelioid cells which we find in the infective granulomata (so-called) to which class the actinomycotic lesions belong. The oat-shaped bodies, seen in the drawing in the left hand lower corner, are undoubtedly clubs separated off from the fungus. The "one inch section" in the upper half of the page fairly well represents the appearances of the lesion ;

we notice the marked fibrous tissue,—*"plenty of fibrous tissue,"* Mr. Smith writes,—and the number of spheroidal bodies, which are no doubt the fungus masses. These cells "look a little like (starch granules)," he says, "but have radiating lines running from their circumferences." Apparently Mr. Smith does not quite like his simile, for he encloses the starch granules in brackets. The radiating lines are the rays, and these he, again correctly, describes as "faintly yellow." Although Mr. Smith ends up by saying that he has seen just the same appearance in ossifying fibrous tissue or in periosteum and in feline cranial bones, I must question this ; nor does he himself seem to be quite certain about it.

It is evident, then, that independently Mr. Smith had discovered the ray fungus ten years later than Langenbeck, and like him had drawn it without knowing what lay before him. Unfortunately he had no Israel to secure the fungus for him. I also

understand that the sections and specimens described by Mr. Smith were obtained from a tumour of the upper jaw—a significant point.

To me this little sheet of notepaper, fading and soiled with age, was of great interest, and I am grateful to both Mr. Smith and Mr. Rudolf Smith for permitting me to record this unobserved and hidden discovery. With insufficient microscopes and coarser methods our masters and teachers knew how to achieve great results, and knew how to make good and sound observations. Unfortunately,



this one was doomed to obscurity, but that matters not, to me at least, for I admire the objective description and the truthful drawing, and the acute eye that recognises the unknown, even though the mind fails in grasping it. I doubt not that other Bart.'s men will share this admiration with me.

A Clinical Lecture on the Etiology of Mistakes in Diagnosis.

By HOWARD MARSH, F.R.C.S.



ENTLEMEN,—It is obvious that the results of your treatment must largely depend, in any given case, on the diagnosis that you have formed. Your opinion, in other words, as to what is the matter with a patient determines to a great extent what you do for his relief. Yet that diagnosis is often at fault—either positively erroneous, so that the symptoms observed are attributed to one cause when they are really due to some other; or incomplete and inadequate, so that no precise opinion is arrived at—is a truth with which every one is only too familiar. Now I think it may be useful to study the various causes to which these defects of diagnosis are due,—to endeavour to ascertain how it is that mistakes are so apt to occur. Before we enter upon this act of penance, however, we may fairly remember that great advances in accurate diagnosis have been made in many directions in the course of the last few years.

1. It behoves us all to recollect that *our acquirements may be deficient*. We may be ignorant of what others know, because either our opportunities, or our diligence and attention, have failed us. Or our powers of observation are deficient, our perception is obtuse, so that we do not notice what others see at once. An Indian hunter sees a footprint in his path, or a curl of smoke on the horizon, or he hears a sound which others cannot detect. Wild animals are keen observers: nothing escapes their notice. Our special senses, unless we train them carefully, are poor and rudimentary in comparison with theirs. Yet our sight, our hearing, and our sense of touch may be developed to a high degree of perfection by cultivation. This is best seen when they undergo what may be termed compensatory development. In a blind man the senses of hearing and of touch become so enlarged and intensified that the loss of sight is to a striking extent made good. Yet how few of us adopt the systematic practice of educating our special senses; our sense of sight, for instance, by a standing habit of studying a picture or some other object until we feel sure we really see all that it presents. How often should we have to answer the question, "Did you notice so and so?" by confessing "No, I am afraid I did not." It has been well said that "the eye sees what the eye brings the means of seeing." How keen and highly trained must the faculty of observation be in a great portrait painter. How completely he must see what there is in a face before he can produce a true likeness. In the diagnosis of a case one man will see things which will guide him at once to a correct conclusion. To another, these things, and what they plainly indicate, are as if they did not exist. He completely overlooks them. I remember at a clinical examination showing a candidate a diseased knee-joint, and asking for his diagnosis of the case. The affection was osteo-arthritis. I had no sooner, however, asked the question, than the patient placed his hand, all the finger-joints of which were enlarged and distorted, so that they presented a typical example of the disease, on the front of his thigh within six inches of the knee. With this tell-tale hand in this position, I felt it was useless to pursue the question further. Here, however, I was wrong, for the candidate came to the conclusion that the disease was tuberculosis. He did not in fact see the hand, on which "osteo-arthritis" was so plainly inscribed.

The following story is an old one; nor can I fully vouch for its literal accuracy. But in spite of both these drawbacks, it may still convey a useful lesson. While a quack in a country town was seeing his patients, a woman of thirty-five, who was a complete stranger to him, entered his room and handed him a bottle of urine. After he had inspected the bottle carefully, the following dialogue, history informs us, occurred. This is your husband's? Yes. He is older than you are—he is sixty-three? He is just sixty-four. He is a tailor? Yes. You come from —? (naming a village three or four miles off). Yes. Now, how did he arrive at all these facts? He was a shrewd man, and one who had long cultivated the faculty of close

observation. The woman was married, for she wore a wedding ring. Her husband was living, for she was not in widow's weeds. The specimen did not refer to her own case, for she was evidently strong and well—probably the urine was her husband's. Floating in the bottle he saw a gray hair. This suggested that her husband was old. He saw some "list" (the selvage of cloth) rolled round the cork to make it fit the bottle. This list would be mere waste in a tailor's shop, but rare elsewhere. This indicated that the man was probably a tailor by trade. He noticed that she had some light-coloured loam on her boots, which was to be found in one place, and one place only, in the neighbourhood—the village he had named. Now, although this man was "only a quack," his performance was admirable. Let us learn from him, and remember that no man who does not very carefully train his powers of observation can be completely equipped as a practitioner of medicine or surgery. Many mistakes are the direct outcome of defective observation, or deficient cultivation of the special senses.

2. *Instead of being alert, watchful, and critical, you are careless, inattentive, and off your guard.* In this slack state of mind you may easily overlook a dislocation of the humerus in a stout subject, a Colles' fracture without much displacement, or a small femoral hernia.

3. In a difficult case you omit to repeat your examination when the conditions which at first marked the real state of affairs—such conditions as swelling, severe pain in the part, want of daylight, or the general state of the patient—are removed. A boy of ten, for example, has fallen upon his elbow. When you see him an hour afterwards, and in the dusk of the evening, it may be impossible on account of the swelling to tell what injury has occurred. Or a man is admitted into the hospital when he is tired and jaded so that he looks ill, and his extremities are blue with cold. You find he has a very ugly-looking swelling involving the lower third of his fibula, and you have no doubt the disease is sarcoma. Now if, in these two cases, you pursue your diagnosis no further, you will in all probability treat both of them wrongly, and will materially injure both your patients. In the one case you will act in ignorance of the fact that the boy has sustained a fracture involving his elbow-joint; in the other you will mistake a large periosteal gumma for a sarcoma, and you will fail to prescribe potassium iodide, which would quickly remove the swelling; nay, you may even amputate a limb that ought never to have been removed. If, on the other hand, you proceed to complete your diagnosis when circumstances have become more favorable—when, in the first case, swelling has subsided after the limb has been placed in a favourable position, and when the patient is, if necessary, under an anæsthetic; when, in the second case, the swelling has by rest, warmth, and position been reduced, so to say, to its simplest terms, and when you have learned by going into his history that the patient is affected with tertiary syphilis—you will have no difficulty in arriving at a correct conclusion.

4. *You don't revise your diagnosis.* You forget that a case, as it goes on, may undergo a radical change—that some entirely new element may be introduced. Forgetting this, and as your mind is settled as to the diagnosis, you allow the change that has occurred completely to escape your notice. You are, for instance, attending a patient for gonorrhœal orchitis, or a young adult for a severe sprain of the wrist. Now in both cases—and I have myself seen examples of the occurrence—the parts concerned may become tuberculous. But unless you are in the habit of revising your diagnosis, the development of this new element, this radical change in the nature of the affection, may totally escape your observation. It is only when much valuable time has been lost, and when the condition at length forces itself upon your notice, or when perhaps your diagnosis is revised by some one else, that your oversight is detected. This engrafting of a new and widely different element upon a case in which the original diagnosis was quite obvious may very easily entrap you. I have seen the following among many illustrations of it. A woman had an ordinary abscess in the breast after her infant was weaned. The abscess was opened in due course, and a drainage-tube was inserted. A sinus remained, discharging a small quantity of pus. At the end of two months, when the patient first came to the hospital, it was quite obvious that, occupying the situation of the deeper part of the abscess, was a large mass of scirrhus. This I removed, and microscopic examination left no doubt as to the nature of the growth. A man, with stricture of long standing, had several urinary fistulæ traversing his scrotum. He had been many months in this condition. At length, however, swelling of the scrotum rapidly increased, and it became plain that a malignant growth was in process of development. Sir James Paget* tells that "a boy fell and struck his knee. It had been perfectly healthy, but the inflammatory swelling (as it was supposed) that followed the fall did not subside—rather it constantly increased, and in a few weeks it became

* Surg. Pathol., 1870, p. 685.

probable that a large medullary tumour" (doubtless the growth was really a periosteal sarcoma) "was growing round the lower end of the femur. Amputation proved this to be the case." He also relates that "a sturdy man, at his work, slipped, and strained, or perhaps broke, his fibula. Three days afterwards he had increased pain in the injured part, and at the end of a week, swelling . . . constantly increased. Eight weeks after the injury the swelling was found to be a large medullary growth" (periosteal sarcoma?) "around and within the shaft of the fibula, and the limb was amputated." I have myself seen a sarcoma develop at the site of a recent fracture of the humerus.

5. *You overlook some possibility which you ought to have taken into account, and you can only say "I never thought of that," or "That never occurred to me."* Thus, in a case in which the patient has angular curvature of the spine, you think only of Pott's disease; you forget that either primary sarcoma, or carcinoma secondary to carcinoma of the breast or some other part may also produce angular curvature. Two examples of this oversight, and in which angular curvature was due to malignant disease, have recently come under observation. Or in a case of abscess in the floor of the mouth you overlook a salivary calculus. Or you overlook the fact that acute cystitis may be due to gout, or that pruritus vulvæ may be caused by diabetes. An amusing illustration of this kind of oversight is afforded by the following anecdote. A patient, many years ago, presented symptoms which it was found hard to account for. Amongst them was a contracted and fixed pupil of one eye. The old family butler having heard this symptom earnestly discussed on two occasions, said to one of the learned doctors while a third consultation was going on, "Please, sir, I don't know if it makes any difference, but master has got a glass eye."

6. *The governing facts of the case are not as you suppose.* In other words, your premises are wrong. A sufficiently good example of this is found in an incident which came under the notice of Mr. Thomas Smith. An individual who had more money than either good manners or self-control, was assisted from his dining-room to his bedroom, where he fell heavily asleep. Shortly afterwards he greatly alarmed his wife by the difficulty of his breathing, which seemed to her to indicate more than mere intoxication. As his false teeth, which he usually, on going to bed, left in his dressing-room, were nowhere to be found, his wife feared they had slipped down his throat; she therefore sent off the groom post-haste for the doctor, who, when he came, made immediate preparations for extracting the foreign body. At this juncture, however, the butler came into the room with the teeth on a silver salver, and said he had found them stuck in the pine-apple. Some years ago a man was brought to one of the London hospitals, having met with a severe accident. As it was found on examination that there was a dorsal dislocation of the femur, the patient, who was somewhat intoxicated, was placed carefully under an anæsthetic, and an attempt to reduce the displacement was made; but this failed, and further treatment was postponed. Next morning, however, it transpired that the dislocation had occurred many years before. One other case. A man, thrown in the hunting-field, lay on the ground insensible. A sporting bone-setter, who happened to be at hand, finding the man's neck all awry, jumped off his horse, raised the patient's shoulders, and, placing his knee at the nape of his neck, began pulling at his head to "put his neck in." This energetic usage brought the patient sharply to his senses; and on thus recovering himself and realising what the bone-setter was doing, he shouted "Born so, born so!" In fact he had had a wryneck all his life. Gentlemen, I sincerely hope these incidents may not seem to you to be related in any spirit of unbecoming levity, or in any sense idly. I use them in the hope that they may impress upon you the very serious importance of being careful that the facts of the case you are about to treat are really as you suppose them to be.

7. *You overlook collateral evidence, e.g. of syphilis, or tuberculosis.* Thus in a case of chronic inflammation of the bladder—although you examine other parts fully—you may overlook a small swelling in the globus major of the epididymis, which, had you noticed it, would have strongly suggested that the cystitis was tuberculous.

8. *Diagnosis may be impossible because the disease is unknown.* Anyone who met with a case of Charcot's disease in, let us say, 1865, must have failed to recognise it, for the affection was first described in 1868; while until recently such conditions as syphilis of the joints, osteitis deformans, anthrax, actinomycosis, infantile scurvy and syringomyelia were unknown. At present, no doubt, there are many diseases that have yet to be found out.

9. *In some cases a correct diagnosis may be impracticable.* Thus a child twelve months old, who had previously appeared perfectly well, was, while in its mother's arms, suddenly seized with urgent dyspnoea. It had nothing in its hand just before, and had not been recently fed. The symptoms, however, pointed strongly to a foreign body in the

air-passages. Tracheotomy was performed, but, though a little relieved at first, the child died within an hour and three quarters of the onset of the attack. *Post-mortem* examination showed that a caseous bronchial gland had passed through a circular clean-cut opening into the trachea, and had completely obstructed the right and partially occluded the left bronchus. This remarkable case is related by Mr. R. W. Parker in the twenty-fourth volume of the *Clinical Society's Transactions*.

10. *Characteristic or conclusive symptoms are absent.* A patient has, you suspect, stone in the bladder, but although your suspicion is correct, on sounding you cannot detect it. This may be either because it is lodged behind the prostate, where an ordinary sound cannot be made to strike it, or because it is encysted—for there are such things as encysted stones, although they are very rare. You will agree with me that the conclusive symptoms of fracture of a bone are deformity, preternatural mobility, and crepitus. Yet there are many fractures in which these symptoms are absent, or inappreciable; they are often absent in fracture of the clavicle in children, and they may be inappreciable in impacted fracture of the neck of the femur, in fracture of the pelvis, and, of course, in fracture of the skull.

11. *The same symptoms may be common to two quite different conditions.* To illustrate this, take the case of an enlargement of the head of the tibia, which you believe is either inflammatory or a sarcoma. How will you decide which condition is present? (a) A history of injury would suggest inflammation; yet cases have been given above in which sarcoma followed rapidly upon an injury of the part. (b) As to the shape of the enlargement—a fusiform contour, symmetrical and free from lobes, or irregular bulging, would point rather to inflammatory swelling than to a new growth. Yet a new growth may be smooth, fusiform, and symmetrical, and an inflammatory swelling may involve one side of the bone only, and present a quite irregular outline. (c) An inflammatory swelling may be, as to consistence, quite firm; or, on the other hand, more or less soft, when the superjacent tissues have become infiltrated and are breaking down. In a similar way a periosteal sarcoma may be either firm like bone, or broken down and so elastic that the sense of fluctuation is very closely imitated. (d) As to rate of increase. An inflammatory swelling may increase either quickly or very slowly; and precisely the same may be said of new growths—a myeloid sarcoma may grow slowly, a periosteal sarcoma rapidly. (e) Enlarged and tortuous veins and a dusky appearance of the surface indicate obstruction to the venous return; and although they are no doubt more common and more pronounced in cases of new growths, yet they are without doubt met with also over inflammatory enlargements. (f) Pain may be either well marked or trivial, or even entirely absent, both in inflammatory swellings and in new growths. (g) As to the patient's temperature. This in inflammation of the tibia may be quite normal, or it may be considerably raised. And exactly the same is true when the affection is a new growth. In a case of myeloid sarcoma, slowly increasing, the temperature is usually normal; but I have met with several cases of periosteal sarcoma in which the temperature, in the patient's axilla, was between 101° and 103°. Here, then, are seven symptoms which are common to two such radically different conditions as inflammation and new growth; and the result of this circumstance has been that the two affections have been frequently confounded. Inflammatory swelling has been taken for a new growth, and a new growth has been taken for an inflammatory swelling; and, so, grave errors of treatment have occurred. Such errors can only be avoided by most thorough study of the case from every point of view, and by abstaining from radical treatment until an exploratory operation has been resorted to.

12. *You attribute the symptoms you observe to one cause, when they are really due to some other.* Last year my attention was drawn to a boy of twelve, who three days before had fallen upon his tuber ischii while he was sliding on some ice. He had complained of severe pain, and the part was somewhat swollen and very tender on pressure. His general condition appeared to be very grave. He had severe headache, and was delirious, his temperature was 103°, his pulse 120, and he looked flushed, heavy and dull. The boy's high fever, delirium, rapid pulse, &c., made me afraid that he had as the result of his injury acute infective periostitis and septicæmia. I do not see how this suspicion could have failed to arise in the mind of anyone familiar with that formidable condition. I had chloroform given at once, and I carefully examined the injured part, expecting, I own, to find evidences of mischief that would require a free incision through the periosteum; but I could make out nothing beyond some swelling, such as might follow an ordinary bruise. The tuber ischii seemed quite normal. Boracic fomentations were therefore applied, and we were all interested to see what course the case would take. Well, in two days the boy had perfectly recovered, and then it seemed clear that he had merely

had a sharp attack of influenza, an epidemic of which was raging at the time.

A man of twenty-three was some few years ago admitted into the old Lazarus ward with "acute gonorrhoea and orchitis." He had a copious urethral discharge, and there was a swelling in the right side of the scrotum, just as if he had very acute orchitis. The skin was dusky, and the part extremely tender. When I saw the patient an hour later I was struck with his general appearance and his symptoms. He was pale, and his forehead was bedewed with beads of perspiration. His pulse was rapid and small, he was sick, and in very great pain and very restless. On further examination I found that his abdominal muscles were rigid, that his abdomen was tympanitic and tender on even slight pressure, and that the swelling in the scrotum was distinctly resonant on light percussion; in short, that the man was evidently not suffering from orchitis, but from acute strangulated hernia, and he was at once submitted to operation.

13. *You forget that the case may be neuromimetic.* A girl of fourteen was admitted into the hospital presenting all the appearances of old hip disease with loss of movement, and long-standing flexion and adduction—showing themselves in the compensatory postures of lordosis, and apparent shortening. I confess I was completely deceived, as others had been; and I made preparations for the treatment of the case by weight-extension in the long axis of the femur. The girl's position, however, was so bad that I had her placed under ether in the hope that I might be able, without using any force,* to "unfold" the limb and bring it into a somewhat more manageable position to start with. When she was asleep we were much surprised to find that the limb had passed into a normal position, and was perfectly movable in every direction. As soon, however, as she recovered consciousness, the full amount of previous distortion and of muscular rigidity forthwith returned. This girl ultimately recovered perfectly under massage, and Sister Stanley's judicious management.

All are familiar with these neuromimetic cases of joints, spines, talipes, &c. Yet you will not find it easy in dealing with them to avoid mistakes and oversights which may have a tragic effect on your reputation in the early years of practice, especially if you have a bone-setter in the neighbourhood.

14. *You forget that your patient may be shamming.* Many of you will recall the case of a young woman lately in one of the wards who had a strange-looking oedema of her upper extremity. I was asked by Mr. Gay, of Putney, to take her in, so that, if possible, we might bring her to the mind of discontinuing the trick of producing this oedema by tying something tightly round the upper part of the limb. When she found that the dressers, sister, and nurses all knew about her, and that she produced the swelling herself, she discontinued the tricks, and she was discharged with the limb in a normal condition. Three or four days ago, however, she came, looking the picture of innocence, with the arm again swollen, and with several sores on the forearm, which, there could be no reasonable doubt, she had herself produced. Some of you will also remember that in the course of the summer Mr. Willett showed, at one of the Thursday consultations, a young woman who had a very extraordinary condition of her left lower limb. The limb was in a state of tense oedema nearly up to the groin. Her opposite limb had been amputated for elephantiasis some years previously, and she now wished this limb also to be removed. On investigation it was conclusively proved that she produced the oedema by tying something round the top of the thigh. The remarkable point about this case was that the patient came into the Hospital for the express and declared purpose of having the limb amputated. A girl of fourteen had an odd-looking ulcer on the back of her hand. Was it lupus, or an aggravated chilblain, or what? We found out that she produced and maintained it by constantly picking it and irritating it in various ways. We put her hand on a splint, and covered the ulcer with a shield which she could not remove. The ulcer healed. We twice discontinued the splint and shield, and the ulcer on both occasions returned; but it soon healed when they were reapplied. Dr. Savage told me lately of a young lady whose mother was horrified by a terrible sore on her wrist. The girl made light of it, and seemed—in order to save her mother's feelings—to bear the distressing condition with great fortitude. Dr. Savage, however, found that the sore was of her own production. He saw her, when she thought she was not observed, tear off the strapping and lacerate the granulations till they dripped with blood, and all this without betraying herself by even a look of discomfort. Many other cases of shamming could be mentioned; but I will here refer to only one, that I have lately seen. A girl of eleven was said to have a very strange condition of her fingers, consisting of free perspiration around the roots of the nails, with the further peculiarity that the exuded fluid was mixed with a large number of fine

air-bubbles. In a few days her parents were distressed to find that a similar condition involved many of the toes. The wonder still grew, and it was noticed that oozing had begun also at the umbilicus, which was occupied by a frothy fluid. It was very early strongly suspected that the appearances were produced by the child herself—by some trick, and on examination the fluid was ascertained to be saliva: in fact, she had been spitting into her finger and toe nails, and into her umbilicus. Her feet, therefore, were enclosed in splints, and covered up so that her plans thus far were defeated; but when the coverings a day or two later were removed, the deeper layers were found quite wet and soaking, and the fluid turned out to be urine which she had dribbled in between her skin and the splints.

The subject of shamming is one of much clinical importance, and one that will call for all the sharpness, discrimination, and judicial temper you may possess. Some imposters have had so much practice, and have learnt so much about the symptoms of the complaint they pretend to be suffering from, that they are very likely to deceive you. When I was house surgeon a woman on one or two occasions obtained admission into the medical wards by shamming intestinal obstruction. She said she had severe pain and abdominal tenderness, and declared she had been very sick, and on examination it was found that her abdomen was tensely distended and tympanitic. When her fraud was detected she made a full confession—and then departed, no doubt, "to fresh fields and pastures new." On the other hand, you may believe a patient is shamming when in reality he is suffering from some serious illness, or the results of a serious accident. Many years ago a house surgeon felt convinced that a highly loquacious and picturesque Irishman who had fallen down was not really hurt, but was shamming in order that he might be taken into the hospital. He therefore made him get out of bed and attempt to walk. After a couple of steps, however, the man gave a sudden cry of pain, and would have fallen had he not been supported. He was then found to have all the symptoms of an extra-capsular fracture of the neck of the femur, which, until he was made to throw his weight upon the limb, had been firmly impacted. In cases in which you suspect shamming it is advisable not to say anything to wound the patient's feelings, and not to use any test that may possibly do harm, for your suspicion may be completely unfounded.

Much more might be added under the title of this lecture, but I hope I have said enough to induce you to study the principles of diagnosis very carefully for yourselves.

The Causes and Treatment of Nasal Obstruction in Children.*

By ANTHONY A. BOWLEY, F.R.C.S.,
Assistant Surgeon to the Hospital.

MAY I commence by asking you to consider for a few minutes the functions of the nasal cavities themselves? for before we can appreciate the effects of diseased conditions it is evidently advisable to have clear views of the uses of the parts when healthy.

Sense of smell.—The most obvious use of the nose is to smell with, and for the proper exercise of this function it is primarily necessary that the odorous substance shall be drawn through the nostrils with a current of air; for, in the absence of this ability to respire through the nostrils, the latter may be plugged with the most pungent substances without their presence being perceived. It follows, therefore, that any hindrance to nasal respiration will result in partial or complete loss of ability to smell, so that nasal polypi, swollen turbinate bodies, a deviated septum, adenoid growth, &c., may cause impairment of this sense.

Next, the perception of an odour is dependent on a healthy state of the mucous membrane of the nose itself, and consequently of the terminal distribution of the branches of the olfactory nerve, so that in various abnormal conditions of the nasal mucous membrane the sense of smell may be deficient, and even when the sickening smell of ozæna is present the patient is unable to perceive that which annoys every one in his neighbourhood.

Thirdly, a healthy condition of the olfactory nerve, and the corresponding part of the brain is necessary for the perception of smell.

The most important function of the nose, however, is as an *organ of respiration*, and it would be well if it were more fully appreciated by mankind at large that the nose, and not the mouth, is the natural

* Diseases of the Joints and Spine, 1896.

* A paper read before a meeting of the North-Eastern Division of the Metropolitan Counties Branch of the British Medical Association.

passage for the air. The most obvious benefit of nasal respiration is the warming and moistening of the respired air, so that by the time the latter has reached the pharynx it is saturated with moisture, and is warmed to about 80°–86° Fahrenheit. This heating and moistening is mainly due to the turbinate bodies, which, being composed of a very vascular erectile tissue, and controlled by the most delicate vaso-motor nerves, dilate or contract according as the air passing over them is either cold and dry, or warm and moist. It thus results that the mucous membrane of the pharynx and larynx are not dried or chilled by the impact of dry and cold air, and that when they are not so protected by nasal respiration they sooner or later suffer in consequence, and pharyngeal catarrh and recurrent attacks of laryngitis result.

Voice.—The extent to which the character of the voice is dependent on the free passage of air through the nose is a matter of such common knowledge that it only needs very brief mention, for, apart from the fact that the upper or "head notes" of the singing voice cannot be produced with blocked nares, the air in the nasal cavities is thrown into vibrations with every oral sound, and the character or quality of the voice depends largely on this resonance of the air in the nasal cavities.

Finally, the freedom of nasal respiration is essential to the *sense of hearing*, although this is so frequently overlooked that I must ask you to allow me to dilate a little on this point, and to, at any rate, raise the question as to how the sense of hearing is affected.

It may, first of all, be assumed as a fact that the free admission of air to the Eustachian tube and consequently to the tympanum, is necessary for the proper perception of sound. This air obtains admission through the nares under ordinary circumstances, and is passed into the Eustachian tube when the latter is opened by the action of the tensor or levator palati muscles; but even when the anterior nares are blocked, air may pass from the mouth into the naso-pharynx, and thus reach the tympanum, so that the mere stoppage of the nostrils is not sufficient to close the Eustachian tube. The latter is occasionally, though rarely, blocked by nasal tumours, but is much more frequently closed by catarrh; and I cannot doubt that in most cases of deafness arising from disease of the nose or naso-pharynx it is the catarrh of the Eustachian tube, and not the mechanical blocking of it by growth, that causes the difficulty of hearing. Such a catarrhal inflammation may result from extension of a catarrh from either the nares or the naso-pharynx; and whilst temporary deafness is common enough in the simple "cold in the head," the more chronic forms of Eustachian catarrh are only indirectly dependent on obstruction to nasal respiration.

I think myself that adenoid growths of the naso-pharynx are the most common cause of deafness in childhood, but I feel quite certain that they seldom mechanically block the Eustachian tube. It is a fact, of which I can have no doubt, that the size of these growths bears no direct proportion to the deafness resulting from them; and I attribute the latter to the catarrh which is originated and maintained by the growth, and not to their size. It is, however, further, most probable that when air does not freely pass through the nares the action of the muscles of respiration, and the suction action of the thorax must make a definite impression on all the yielding structures which lie within their influence, and consequently we should anticipate that a condition of congestion and oedema would supervene in the soft structures of the nose and naso-pharynx. The mucous membrane of the orifice of the Eustachian tube and of the surrounding nares would share in this abnormal condition, and the result would be an obstruction to the free passage of air to the tympanum. Finally, in the more chronic cases, where nasal obstruction has been of long standing, there may result a chronic catarrh of the Eustachian tube itself, and of the lining membrane of the tympanum, and the swelling of these membranes may not only prevent the due entry of air, but may also impede the passage of the mucus. If these conditions have become established a very little may set up a more acute catarrh of the tympanum, resulting in muco-purulent catarrh, and ultimately in perforation of the membrana tympani. When matters have gone as far as this the road is open to a variety of complications, which I will not endeavour to enumerate.

Discharge from the nose.—And now, having thus briefly passed in review the functions of the nose in respiration, and the results to be expected when its functions are in abeyance, I will next ask you to consider a symptom for the relief of which patients are very commonly brought to us, but which is only of importance as an indication of some affection of the nasal mucous membranes: I allude to "discharge from the nose."

Let us first put on one side the common acute nasal catarrh resulting from exposure to cold or wet, and having done so, let us consider the importance to be attached to the *character of the discharge*

in cases of sufficiently long standing to deserve the name of "chronic."

First. In some cases the discharge is *bloody*, and slight bleeding is easily provoked; in many such cases little portions of blood-clot come away, and most often the discharge is from one nostril alone. The cause of such a condition as this is almost always a foreign body in the nose, and this is especially likely to be the case if the patient be a very young child who can give no definite history, and often is of too tender years to give the least assistance when questioned. For, the introduction of foreign bodies into the nose is not nearly so likely to be done by children over the age of five or six, and if anything is introduced by such children, they usually at once complain, and become alarmed if unable to extract the body themselves. Further, it should be remembered that various substances may be pushed up the nares of infants by children older than themselves, and that in such cases the parents are always inclined to say, on being questioned, that the child has never been known to place anything in its nose, and that the discharge cannot be due to such a cause. As an illustration of this I may mention that some few months ago a child aged three years was brought to me at St. Bartholomew's Hospital with blood-stained discharge from each nostril which had been going on for nearly a year. I pointed out to the students that such a discharge was usually caused by a foreign body, but that it was, of course, generally limited to one side. It was, however, quite possible that the child had a foreign body in each nostril; and such proved to be the case, for, from one side I subsequently removed a button, and from the other nostril a piece of india-rubber. The mother then told me at a later visit that some of the other children had told her since the removal of these materials that they had stuffed them up baby's nose a long time before for fun. Boot buttons appear to be in great favour, but I may remark that almost anything which is not too big may be introduced. With regard to treatment, I would only say that I think it is wise always to examine the patient under chloroform, for the nasal mucous membrane is very sensitive in such cases, and it is impossible to keep the child quiet enough to permit of the introduction of instruments.

Secondly. The discharge may be *purulent*. In such cases the discharge is usually of many months' standing, and probably commenced as a mucous discharge. The patients are generally as old as five or six, and may be older. There is generally neither pain nor swelling of the nose, and nasal respiration is only partially obstructed. There is not usually deafness, and the voice is not altered in tone. On account of the comparative absence of troublesome symptoms such cases are often not brought to the surgeon for many months or years. When the nose of these patients is examined there is comparatively little to be seen beyond some congestion and swelling of the mucous membrane. If treated by attention to the general health, by washing out, and by antiseptic powders, especially by a mixture of equal parts of iodoform and borax, improvement is soon observed, although many months may be required to complete the cure. In all these cases also the general health is often at fault, and the stomach and the digestive functions require special care and attention.

It remains to be mentioned that in some few cases blood-stained discharge, mixed with muco-purulent secretion, is due to *syphilitic ulceration*; but this, though common in older people with acquired disease, is rarer in children with congenital syphilis. It should also be noticed that in such cases in childhood there is almost always some thickening and swelling of the whole nose, and especially of its bony parts, the result of inflammation of the bone and the periosteum; whereas in other cases of rhinitis the inflammation is limited to the mucous membrane. In syphilitic cases also there is frequently ulceration of the palate or fauces, and in some of them ozena is present.

Thirdly, the discharge may be very slight in quantity, but thick, tenacious, and difficult to remove; it tends to form crusts and scabs, which are dark and often blood-stained. There is loss of sense of smell, but the breath of the patient is offensive, and characterised by the sickly, nauseous odour which is only smelt in cases of ozena. Nasal respiration is often free, but may be obstructed by the crust formation in the nostrils. Hearing is not affected until after the lapse of many years, and naso-pharyngeal catarrh is common. This affection does not occur in very young children, is hardly ever seen before the age of about ten or twelve years, and is now commonly named "*atrophic rhinitis*." An inspection of the nares justifies this term, for here, instead of finding swelling and congestion of the nasal mucous membrane, it is found that the turbinate bodies are much shrunken and flattened, and the mucous membrane is thin and stretched; the whole nasal cavities appear more large and roomy than natural, but on various parts of the walls are attached the thick blackish or brown crusts already mentioned.

Now I particularly desire to direct your attention to this affection for several reasons. Atrophic rhinitis is one of the most serious diseases of the nose, because, by reason of the offensive *ozæna*, it renders the individual obnoxious to all in his neighbourhood, is a source of constant misery, and may absolutely prevent the patient from following many occupations. It is, when fully established, quite incurable, and lasts for the whole of the victim's lifetime. It is said that it is seldom seen before the age of ten or twelve years, but may commence as late as fifteen, or perhaps twenty. What I am particularly interested in, however, is its earlier history. How does it begin? What are its earlier stages? Can it be prevented? There is a good deal of difference of opinion on these points, but I will first of all express my own. I believe that it is always preceded by chronic catarrhal or purulent rhinitis, and that it is the ultimate result of those conditions when neglected. I am sure it does not result from "hypertrophic rhinitis," and has nothing to do with the latter. May I suggest that this is essentially a subject which can be elucidated by the observation of the general practitioner, and may I ask you if you have observed any cases in which a chronic non-odorous catarrh has been converted into a catarrh with *ozæna* after the lapse of months or years? I often hear histories which would seem to justify the opinion I have formed, but I have not myself personally seen a child with non-odorous catarrh at one time, and at a later period with *ozæna*, and I am most desirous of hearing some expression of opinion on this matter; for if my opinion be a correct one, then, as the preceding condition is a curable one, atrophic rhinitis may be quite prevented.

With regard to treatment I will not attempt to enter into details, but will only say that thorough removal of crusts and then daily washing of the nostrils, either with plain salt and water or with antiseptic fluids, are the first essentials; and that after the daily syringing an antiseptic powder of equal parts of borax and iodoform or iodol should be insufflated, so as to prevent decomposition and its attendant odour.

By such treatment improvement can be produced, but not a cure.

Fourthly, the discharge may be *mucoid* or *mucopurulent*, consisting of thick mucus, with a tendency to form scabs or crusts near to the anterior nares. In such cases there is often some excoriation of the skin of the upper lip and nostrils, and usually there is much obstruction to nasal respiration, and some alteration of the voice. In the more acute cases of this class there is also a good deal of definite inflammatory thickening of the cartilaginous portions of the nose, with tenderness on pressure, and a good deal of pain on introducing a speculum. Deafness is not common.

Here we have to do with a chronic or subacute nasal catarrh, which is at its worst in the anterior part of the nares, and generally yields quickly to the local application of zinc or boracic ointment, with attention to the general health, and special care in feeding, and to the condition of the bowels. I think that most of these cases do best with small doses of grey powder, and feel sure that they owe their origin very frequently to improper feeding and its attending catarrh of the stomach and intestines. In other cases want of ordinary care and cleanliness appears sufficient to cause the catarrh. Most of the cases of this class occur in the children of the poor.

Fifthly, the discharge may be thin and *watery*, although mixed with mucus. In such cases the child is constantly snuffing, and is unable to breathe through its nose properly, whilst its voice is altered but little, and deafness is not common, or, if present, is not very marked.

Such a case as this may turn out to be one of adenoid growths in the pharynx, but if there are no more symptoms than I have mentioned, it will usually be found that the symptoms are due to swelling of the turbinate bodies, especially of the inferior turbinate body. It must, however, be mentioned that when this condition is found—to which the term of "hypertrophic rhinitis" has been given—there may be also adenoid growths, so that the mere discovery of the enlargement of the turbinate bodies is not sufficient to establish a diagnosis. In other cases again hypertrophic rhinitis complicates deviation of the nasal septum.

The treatment of this condition when recognised is very simple, and consists in the application of either the galvano-cautery or of chromic acid to the oedematous tissue at intervals of about a week. I think that the chromic acid is quite as efficacious as the galvano-cautery, and is evidently more accessible. At St. Bartholomew's Hospital it is usually fused on the end of a steel probe over a spirit lamp and then applied through a speculum, care being taken to take up on the probe only one or two crystals of the acid, and not to hold the probe too near to the flame; the first precaution is necessary to ensure that the cauterisation is not too great, and the second to prevent the acid being charred instead of merely fused, and so rendered inert. It is

advisable to treat only one nostril at a time, so as not to make the nose too sore, and the turbinate bodies alone, and not the neighbouring mucous membrane or the septum should be cauterised. When the growth of the turbinate body is excessive and tends to become pedunculated, it is best to treat it as one would a polyp, and remove with a snare the pendulous portion.

(To be continued.)

On Variations of the Pupil during Anæsthesia in the Normal Subject.

By RICHARD GILL, B.Sc., M.B., F.R.C.S.

FOR the purpose of investigating the effects of collateral causes during the action of chloroform and ether in the normal subject, it is necessary to recognise a constant action of these agents. Without such a constant action, or, as it may be called, "the Standard of Anæsthesia," no record, taken with ever so much care, can be of avail in determining the causation of unexpected, even of dangerous signs. For where there are two or more varying causes in operation, it is clear that one must be limited in its action before the influence of the other or others can be defined.

No one will deny that chloroform and ether vary in their effects according to the degree of concentration in which they are administered. How to achieve the constant set of phenomena which characterise the "standard"? The means to this end were set forth in an address delivered before the Abernethian Society by the present writer on November 15th, 1894, entitled "The Measure of Anæsthesia." In it were displayed all the phenomena which had been observed to occur up to and at the moment of the induction of *unconsciousness*, and their variation, and the introduction of new ones during the maintenance of the *unconscious* state. Let it be observed, I used the term *unconsciousness*; for during these first efforts in investigation I took no pains to limit the action of chloroform and ether. It was sufficient to keep the patient quiet, to attain muscular relaxation and insensibility to pain, without any reference to the degree in which these factors were present. The first analysis ensued upon reflecting that the agent in use might be in excess. For the phenomena were grouped into two chief classes: 1. The state of the patient, so far as regarded pulse, respiration, and complexion, being abnormal, the pupil being variously dilated, and sluggish in its reaction, or not reacting to light; 2. The state of the patient normal or nearly so, but the pupil contracted in the majority of cases, or dilated, and very sensitive to light, and contracting readily with air.

By limiting the amount of chloroform (and of ether) the former group was entirely eliminated. This procedure tended to increase the p.c. of the contracted pupil. Out of 2000 successive cases, there were but 100 which presented a dilated pupil during the early period of the anæsthetic state, the method of administration being regulated, but not efficiently. But this state of the pupil did not always, during the whole period of anæsthesia, remain constant. At some period during its progress it dilated, and to varying degrees. In many instances it was associated with dusky complexion, full pulse, and respiratory impediment. It was assumed that these were instances of overdose; relative, because the same amount had previously been sustained without abnormal signs. This assumption ended in the practice of reducing the amount of the agent in use. The pupil, so dilated, contracted again, but after some while again dilated. Once more was the amount reduced, and contraction followed, and a series of observations, conducted in this way, led to this conclusion: during the progress of anæsthesia the resistance of the patient to the agent in use diminished. This law of diminishing resistance clears the way a little more, and teaches us, by anticipating results, to reduce the agent at stated intervals. Still the sensitive pupil was unexplained, and its occurrence prevented a clear and simple statement as to the relation of the pupil to the state of anæsthesia. Eventually it was brought within the boundaries of law. It was shown to be present only in a particular class of patients, which was removed from the normal by this sign—extreme mobility of tissues. This mobility of tissues happens in those (1) who are suffering from acute fever, (2) who have suffered prolonged and severe pain, and (3) who are greatly emaciated.

Thus a distinction was drawn between the effects of chloroform and of ether in the normal subject, and those who are rendered abnormal in the way above described. And it is easy enough to per-

ceive now that with different conditions—with tissues stable and tissues unstable—the effects of the anæsthetic will vary. To sum up the results of these observations—

I. There is a constant set of phenomena characterising the state of anæsthesia induced in normal subjects by the graduated method of administration (described below). This is called the "Normal Anæsthetic State," and to it all other phenomena are referred as the "Standard."

II. There is an abnormal condition—great mobility of tissues—which is associated with, among other changes from the normal, a sensitive pupil. These cases constitute a separate group—deviation from the normal.

III. Alterations in the normal phenomena occur during the progress of anæsthesia in the normal subject; they are called complications of the normal.

I have deemed it essential to my purpose in making this use of the address which I gave to the Abernethian Society, and I have to thank the Society for their kindness in permitting me to do so.

It was by these methods that I came to exclude the excessive action of chloroform and of ether, and to the conclusion that the state of the pupil in normal anæsthesia is pin-point or contracted. But although a clearer view was thus obtained of the anæsthetic action of these agents—and our object should always be to maintain a constant anæsthetic action, manifested in the contracted pupil, as the chief of the phenomena included in the normal state of anæsthesia—yet variations, sometimes suddenly, sometimes gradually appear, and throw doubt on the correctness of the results already accepted as true. Thus anæsthesia is achieved with a contracted pupil; breathing is rhythmical and efficient, but suddenly it becomes impeded, then completely inefficient, and stops within ten seconds from the commencement of the complication. Is chloroform, here, the cause of this grave sign? Let us examine a little more in detail. There was no original alteration in the character of the pulse till air was shut out; then it became slow and bounding. The complexion gradually increased in dusiness with the want of a proper supply of oxygen. The pupil remained contracted, and began to dilate only after respiratory arrest occurred. The state of the pupil excludes a poisonous action of the anæsthetic, for when this is in excess the pupil is invariably dilated more or less according to the greater or less degree of its concentration in the blood. But the mischief may be in the lungs—the (assumed) too concentrated chloroform vapour obstructing the free passage of air. Against this is opposed the fact that up to the time in question the same amount of chloroform had been inspired without any change being observed. The explanation is found in simple mechanical obstruction—the tongue, rendered heavy by an epitheliomatous growth, had fallen back, and, on its being pressed forward respiration was at once restored. Again, during the progress of ether-anæsthesia, at the end of twenty minutes the pupil was found to be partially dilated, the complexion somewhat dusky, and the pulse slightly full. The lower jaw had dropped, and thus brought about a narrowing of the upper aperture of the larynx. CO₂ was gradually increasing in proportion in the blood. The jaw was raised so as to obviate the obstacle to an efficient entry of air. The pupil became smaller, but did not reach the normal state of contraction. Why? Because the ether had not been reduced regularly in accordance with the law of diminishing resistance. When this was done the pupil became pin-point, and remained so to the end of the operation, which lasted fifty minutes. This instance exemplifies the simultaneous operation of two forces, both of which tend to dilate the pupil. Here ether was, for a short while, acting as a narcotic, and causing an effect greater than the circumstances of the case required. But not for long; the observation of the pupil, regularly conducted, prevents this untoward result from attaining any serious prominence.

The following instance is of a different kind. A child, aged 3, was chloroformed. Unconsciousness achieved with a partially dilated pupil. The anæsthetic reduced from three to two drops, and more air given. The pupil contracted, and the state of normal anæsthesia maintained for ten minutes. Then the respiration became shallow, the complexion pallid, and the pupil dilated. The administration was suspended. The child vomited, and then all the abnormal signs vanished. The administration was resumed and the operation completed, the pupil remaining contracted. Now if there were no constant state of anæsthesia, if we had no "standard" to which to refer complications induced by collateral causes during anæsthesia, how could we determine what part, if any, of intercurrent phenomena is due to the proper action of chloroform? In the case just quoted vomiting took place early; but this act may be deferred for some considerable time, and in a few cases it never occurs at all. It is in these latter instances that there is so much room for the misin-

terpretation of the causation of phenomena, and more especially when the action of chloroform is not made constant. At the moment when respiratory inhibition is being brought about by stomacic perturbation, chloroform may be circulating in too great a degree of concentration, but not sufficiently great to cause within a few minutes a fatal termination. Yet respiratory arrest occurs, and is prolonged beyond the normal period of suspended breathing antecedent to the act of vomiting, by reason of the overcharge of chloroform in the lungs. Artificial respiration restores the little patient, but there is no vomiting. Such a series of phenomena may be ascribed to the sole action of chloroform, but erroneously: first, because the same amount of the agent, though in excess, does not cause these phenomena in all other normal children; secondly, because these phenomena are nearly always followed by vomiting. But the difficulty in ascribing the true causation is obvious, and demands some method by which to regulate the action of chloroform so as to produce a constant effect. For example, anæsthesia having pursued a normal course up to the appearance of the dilated pupil, the first thing we have to be quite sure of is (excluding of course the effect of the operation in causing shock, and hæmorrhage suddenly or slowly brought about; change of position leading to diminished breathing power as in cases of empyema; and pressure on the trachea in the removal of solid tumours of the thyroid), has any error been committed in the administration? If we are sure there has been no irregularity on our part; if we have commenced with the pupil contracted, and reduced the quantity of the agent in use according to the law of diminishing resistance, then the cause of the dilated pupil is to be found elsewhere, and may be either (1) partial mechanical obstruction to breathing, (2) stomacic perturbation, or (3) both acting concurrently.

The advantage, therefore, of limiting the action of chloroform to the state of normal anæsthesia is manifest. And it is advantageous not only because the method of attaining it demands continual attention, through the observations made at frequent intervals, and therefore tends to prevent or cause to be recognised, at its early inception, excessive action, but also because the new phenomena are more easily isolated, their cause therefore more readily traced, and the remedy to counteract it put into operation with immediate and full effect.

I proceed now to describe the method in use to gain this desirable end. It embraces the following main principles:

I. Induction of anæsthesia is achieved by the gradual addition of chloroform drop by drop at intervals of twenty seconds, beginning with one drop. Thus you accustom the patient to its influence. If afraid, and the breathing troubled, the intensity of the vapour is not sufficient to add further trouble to respiration. He gains confidence—there is a short interval in which mental emotions either diminish or disappear—and the transition from consciousness to insensibility is gradual, not violent and, as it may be, complicated by the influence of fear on the respiratory and cardio-inhibitory centres. Each patient has a limit, determined by age and the vigour of his constitution. As this limit is reached there is to be observed an alteration in the character of the respiration. It tends to become rhythmical. When it is rhythmical the patient is unconscious. At this time the pupil is to be observed. It may be contracted, or it may be partially or more widely dilated. If the former, it signifies that no excess of the agent is in circulation. If the latter, it indicates either a temporary overdose, or, if struggling have occurred, an increase in the p. c. of CO₂. In either case the pupil is to be reduced to the normal state of contraction by allowing a freer entry of air, and diminishing the amount of chloroform. When it becomes contracted the operation may be begun. (This applies to anæsthesia in the normal subject: where there exists a deviation from the normal—the sensitive pupil—a different procedure is necessitated.)

II. The patient anæsthetic and the operation in progress, to maintain the condition of contracted pupil chloroform has to be gradually reduced by one drop at the end of every five minutes; so that at the end of half an hour not more than three or four drops should be added every twenty seconds in the case of an ordinary healthy adult. If the operation be prolonged beyond this, the next reduction is to take place at forty-five minutes: then two or three drops are continued for the ensuing period of twenty minutes, after which a single drop will be sufficient to carry on the anæsthesia up to the completion of the operation. By constantly reducing the amount in this way the action of chloroform is found to continue uniform. What explains the diminished resistance offered by the patient? Interference with nutrition. The more the blood is impaired by an overdose of chloroform, or the longer the blood is subjected even to the action of the minimum or anæsthetic dose, the more does it become unequal to the discharge of its functions. But there are other factors

which tend to reduce the patient's resistance,—as, for example, loss of blood, suddenly or slowly brought about, and the severity and length of the operation. And these, when present, have to be taken into account, and the chloroform still further regulated to meet the depression they cause.

III. To these chief principles—graduated system of induction, contracted pupil, and diminishing resistance—is to be added the regulation of the amount of chloroform to the state of the respiration whenever this undergoes any variation. Thus the breathing becomes shallow (cause, stomacheal disturbance)—the quantity is at once reduced proportionately; or almost imperceptible (cause, shock from section of the spermatic cord)—the administration is suspended.

By means of this system, the details of which are taught in the practical classes, a constant and uniform anaesthesia is attained, as expressed in the contracted pupil. And the pupil in relation to anaesthesia is the safest sign for our guidance, and must always be frequently observed during its course,—once during every minute with ether, and every half-minute with chloroform. A recent example proves the soundness of this precept, and its practice is rewarded with the first appearance of dangerous conditions, which counteracted at their earliest inception cause no anxiety, but if allowed to ingravescence might terminate fatally. An infant, six months, was chloroformed. Records of the pupil, taken every half-minute up to ten minutes, indicated normal anaesthesia. Within thirty seconds from the last observation the pupil suddenly dilated—the child had previously been rolled on to the left side. The breathing was shallow and the lips slightly livid. The lint was immediately removed, the jaw drawn forward. The complexion at once lost its livid hue, and the breathing improved. But though the pupil became less dilated, it did not reach contraction, nor did the breathing become free. Hence partial mechanical obstruction is not the sole cause of the danger. Vomiting took place; and immediately after the removal of the second disturbing cause the pupil contracted, the respiration became normal, and the operation was completed. Had not this condition been detected at its beginning, and chloroform still continued, it is evident the condition would have been rendered most grave, for the presence of a relative excess of chloroform in the lungs (same amount of chloroform with diminished breathing resulting in overdose) impedes the act of vomiting, which during the interval is inhibiting respiration. And it is by this action of chloroform at a critical juncture that I believe many fatalities are caused. The same amount is given, and the wonder is that what before had been innocuous should now be dangerous. A false impression is cherished, and the action of chloroform is supposed to be irregular. And, indeed, there is some slender basis for this conclusion, in the fact that at the moment of danger, and previous to it, the amount was not sufficient to kill. But this is not a complete survey of the problem. One factor, and the chief, in bringing about the grave condition is overlooked. Observation of phenomena antecedent to embarrassed or arrested breathing is wanting, or at best imperfect. Perhaps the patient is said to have become pale, ascribed erroneously to cardiac syncope, just before respiration stopped. But the presence of an "undue" amount of chloroform in the lungs, not in itself capable of producing death under normal conditions, but sufficing to still further labour or even arrest respiration, already seriously affected by the inhibiting influence of the stomach, is not taken into consideration. The operation of two forces acting concurrently to produce the same result—the stomach first inhibiting normal respiration, and then chloroform, as a mechanical barrier under the new conditions, tending to increase the already existing burden of respiration—is, however, the true explanation of what, in many instances, becomes a crisis. Neither of these factors (always supposing chloroform not to have been irregularly increasing in amount) is of itself sufficient to kill; but both together may, and it depends upon the relative concentration of chloroform in the lungs whether they will. It becomes, therefore, of paramount importance to keep a watchful eye on the pupil, so that as soon as dilatation is observed the quantity of chloroform may be regulated at once, or its use suspended if necessary.

The pupil not only indicates by its contraction the state of anaesthesia, but also by variations in its size heralds the onset of danger. And during the progress of normal anaesthesia (the pupil being contracted up to the time when the intercurrent cause begins to act), as there are several causes of dilatation, so its conduct varies. There is the gradual dilatation, associated with sluggish reaction to light, of a gradually increasing overdose. There is the widening pupil of returning consciousness, very readily reacting to light. Both these forms belong to errors in administration. Next is the gradual dilatation of the pupil belonging to increased and increasing CO₂ in the blood from partial mechanical obstruction to respiration. It also is sluggish to light, but is separated from the pupil of overdose by

the help of the following phenomena:—When due to + CO₂ the complexion becomes dusky before pupil dilates; when due to + anaesthetic the duskiness of the complexion and the dilatation of the pupil proceed *pari passu*. Again, the breathing is perceptibly affected as soon as the mechanical cause begins to act, and proportionately to its degree of action; on the other hand, with + anaesthetic, the breathing is not perceptibly influenced until the pupil is partially dilated. The remedy in this instance is to support the lower jaw, or, if necessary, to press forward the tongue. The effects of this cause vary in ether and in chloroform anaesthesia. In short operations, supposing a normal subject with healthy heart, the least harm is done; this becomes greater in patients whose vitality is reduced or whose hearts are diseased through the deteriorated state of the blood, leading to impaired nutrition of the tissues. When this impairment of nutrition is continued for some while, as in long operations extending over an hour, the ultimate result must become evident even in the most vigorous constitutions; and if the heart be initially enfeebled, it is quite possible that this organ, unable to repair the waste effected in attempting to overcome a constant, or it may be increasing obstacle to the circulation, and burdened also by distension of its right cavities, may prove unequal to its task. The heart stops, respiration proceeds, and the result is ascribed, falsely if the above succession of phenomena be the true one, to some peculiar action of chloroform.

It is in the influence of stomacheal disturbance, the last cause of the dilated pupil in normal anaesthesia, that this paper has its origin. I have set forth the dangers that may attend it, isolated the secondary part which chloroform plays to it, and formulated the line of practice requisite to obviate the transition of danger into death. But the action of the stomach is not uniform, at least so far as its results are concerned. Thus, though it is common enough to observe the gradual ingravescence of the signs which are our guide, the gradual impairment of respiration till it become scarcely perceptible, and the deepening pallor (of vaso-motor production), though these may continue for a period extending even beyond half an hour (and I have known several instances where vomiting was delayed until consciousness was nearly restored), yet they may appear and grow with such surprising rapidity that only the most careful attention will detect their completed course. I have observed in some instances that where the onset has been rapid, the vomited matter was large in quantity. And perhaps the varying distension of the stomach is the cause of the differences in the quickness with which the disturbed stomach acts. But, however that may be, this maxim should always be followed,—never to attempt to check the action of the disturbed stomach by an increase of chloroform. On the other hand, our aim is always to regulate the amount of chloroform to the new condition of respiration, still reducing the former as the latter becomes more shallow, with the object of anticipating the temporary arrest antecedent to vomiting, and thus leaving the abnormal course of the respiratory mechanism untrammelled by the presence of (under the new conditions) too much chloroform.

Pathological Laboratory.

THE next course of Bacteriology (Elementary as well as D.P.H.) begins on Wednesday, January 15th, at 2.30 p.m. The class will meet on Mondays, Wednesdays, and Thursdays at 2.30 p.m. Gentlemen wishing to attend are requested to communicate with Dr. Kanthack at once.

The demonstrations on Morbid Histology will begin on Friday, January 17th, at 4.15 p.m. The subject for this term is Medical Morbid Histology.

Gentlemen wishing to act as clerks in the Pathological Laboratory from February to April, 1896, are requested to communicate with Dr. Kanthack at once. Clerks are required also to assist Mr. J. Berry (Surgical Pathology), and Drs. Garrod and Calvert (Medical Pathology).

PATHOLOGIST'S REPORT.

From April 1st to December 31st, 1895, 432 specimens have been sent up to the Pathological Laboratory for investigation. The number of specimens sent up is gradually increasing, as shown by following table:

April 25 specimens.	Sept. 41 specimens.
May 34 "	Oct. 41 "
June 31 "	Nov. 79 "
July 45 "	Dec. 94 "
Aug. 35 "	No date given, 7.

Specimens were sent up by the following physicians and surgeons:

Sir Dyce Duckworth . . .	55	Mr. Willett . . .	8
Dr. Gee . . .	43	Dr. West . . .	6
Dr. Champneys . . .	39	Mr. Bruce Clark . . .	4
Mr. Butlin . . .	32	Mr. Lockwood . . .	4
Dr. Hensley . . .	28	Mr. Walsham . . .	3
Mr. Bowlby . . .	25	Mr. Vernon . . .	3
Dr. Brunton . . .	23	Mr. H. Cripps . . .	3
Dr. Griffith . . .	18	Dr. Moore . . .	1
Dr. Church . . .	17	Dr. Andrewes . . .	1
Mr. Langton . . .	16	Dr. Drysdale . . .	1
Mr. Jessop . . .	16	No physician or surgeon	
Mr. Marsh . . .	14	mentioned . . .	64
Mr. Smith . . .	8		

These specimens are distributed amongst the various wards and departments as follows:

Radcliffe . . .	99	Coborn . . .	6
Martha . . .	52	Kenton . . .	5
John . . .	28	Rahere . . .	5
Hope . . .	20	Wardmaids . . .	5
Matthew . . .	18	Pitcairn . . .	4
Throat Department . . .	17	Surgery . . .	4
Sitwell . . .	15	Harley . . .	4
Nurses' Home . . .	14	Isolation . . .	4
Elizabeth . . .	12	Lawrence . . .	4
Luke . . .	11	Henry . . .	4
Colston . . .	11	Abernethy . . .	3
Ophthalmic . . .	10	Paget . . .	3
Darker . . .	10	President . . .	3
Casualty . . .	8	Surgical P.M. . .	2
Out-patients . . .	8	Faith . . .	2
Stanley . . .	8	Mary . . .	2
Lucas . . .	7	Skin Department . . .	1
Charity . . .	6	No ward mentioned . . .	11
Mark . . .	6		

As to the nature of investigation most frequently required, the following table gives some information:

Diphtheria diagnosis . . .	165	Urine examinations . . .	23
Blood examinations . . .	40	Histological examinations . . .	102
Sputum examinations . . .	19		

Notes.

THE Lord Chancellor has ordered that the name of Hubert Nicholls, M.A., M.B.Cantab., be added to the Commission of Peace for the Borough of Longton.

THE new Steward is Mr. Arthur Watkins. He was appointed to the Counting House in 1879 and made Senior Assistant to the Steward in 1889.

MR. E. C. CRIPPS, one of the late Sir Wm. Savory's House Surgeons (1878), is giving courses of lectures on "Domestic and Personal Hygiene" in the villages in the neighbourhood of Cirencester during the present winter. Mr. Cripps gave a course of lectures on the same subject last winter in Cirencester under the auspices of the Gloucestershire County Council.

DR. CLAYE SHAW'S Class in Mental Physiology was well attended not only by Bart's men, but also by students of other Hospitals. Amongst those from other Schools who attended, the following have passed the M.D.:—C. J. Woollett of Charing Cross, R. M. Smyth of St. Mary's, R. H. Castellote, P. S. Eves, J. Le M. Bunch, and S. Williams of University College, E. R. P. Taylor of Westminster, and V. W. Low of St. Mary's.

It has been decided to again arrange a cricket match between "Past and Present" Bart's men. It will take place on the Club ground at Winchmore Hill about the middle of June. The occasion affords a good opportunity for old Bart's men to see the new ground and pavilion which the Amalgamated Clubs have at last obtained, and which was opened last June.

* * *

For those who wish to live "on the premises," and who cannot get rooms in college, a very good substitute has been supplied by Miss Cross, of "bun-shop" fame. The rooms look exceedingly comfortable, and our long acquaintance with Miss Cross, extending far back into the days when she ruled the Smithfield "A.B.C.," assures us that their occupants will be well looked after.

We understand also that Miss Cross has "bed and breakfast" accommodation for those who stay up for late operations, and who have in days of yore spent their nights either on a college floor or a house surgeon's sofa.

* * *

DR. F. H. CARTER (Putney) has for the second time won the Wemyss Silver Challenge Cup, with a dozen golf-balls, in the recent autumn meeting of the London Scottish Golf Club on Wimbledon Common, with the score of 87 - 10 = 77.

* * *

IT MUST be very gratifying that the Gold Medal at the M.D. London Examination has again been carried off by a Bart's man. This is the third time in four years that it has been awarded to a student in our School—

1892 . . .	C. Coles.
1893 . . .	H. G. Cook.
1895 . . .	C. H. Roberts.

* * *

OUR SUCCESSES in the pass M.D. London are also satisfactory. There were thirteen candidates, ten of whom were successful.

* * *

WE SEE in the *Strand Magazine* (Christmas Number) a very interesting paper on "Street Toys," by Mr. E. C. Fincham, one of our most successful amateur photographers. The paper is interesting from its nature, but Mr. Fincham has illustrated it with a large series of admirable photographs taken by himself. The photographs reflect very great credit on Mr. Fincham.

Amalgamated Clubs.

NEW MEMBERS.

J. Valerie.	G. H. Orton.
K. R. Kay.	W. S. Darby.
M. H. Gordon.	C. Dix.
C. F. Bluett.	

RUGBY FOOTBALL CLUB.

The results of the matches have been on the whole very satisfactory. Out of 12 played 6 have been won, 2 drawn, and 4 lost. The matches won were against Streatham, Ealing, Marlborough Nomads,

R.N.C., Upper Clapton, and Rugby, while those drawn were with Civil Service and Lennox. Defeats were suffered at the hands of Wickham Park, Cooper's Hill, Portsmouth, and Harlequins; Wickham Park and Portsmouth winning by the narrow margins of a penalty goal and a try respectively. Ten goals and 14 tries, or 90 points, have been scored for, while 3 goals and 7 tries, or 35 points, against us, so that there is still a good balance of points to our credit. We were very unfortunate in placing a weak team in the field against Wickham Park, there being no less than eight of the regular XV absent. There can be little doubt that with a full team we should have won. Against Portsmouth, too, we played below our full strength, and were defeated by 1 try to *nil*. The team fell off rather towards the end of the term, chiefly owing to the inability of some members to play regularly, so that we rarely had the same team playing on two consecutive Saturdays. We badly want another three-quarter, as Randolph has again hurt his knee, and is doubtful of playing again. It is to be hoped that some talent will be discovered this term, as the Cup ties are near at hand. The 2nd XV has played 11 matches, of which 4 have been won, 6 lost, and 1 drawn. The wins have been against Civil Service, Maidstone, Wickham Park, and West London, while the matches with Mill Hill School, U.C.S. Old Boys, Upper Clapton, St. Thomas's Hospital, Guy's Hospital, and Marlborough Nomads have been lost, and the match with University College School drawn.

ST. BART.'S v. HARLEQUINS.

Played at Chiswick on December 21st, and resulted in a win for the Harlequins by 2 goals and 2 tries to *nil*, although the game was not so one-sided as the score would indicate. The Harlequins put a very strong side into the field, including C. M. Wells, the international half-back. The forwards were fairly evenly matched, but outside we were altogether outclassed. The scrums at first were very stubborn, but gradually we were forced back, and C. Wells scored the first try after a good bout of passing. Shortly afterwards Thornton scored the second try. Up to half time nothing more was scored, and we crossed over with 2 goals against us. In the second half play was of a fairly even character. Bennett made a good run for us and was near scoring. The Harlequins scored 2 tries—Clarke and Edward—neither of which was converted. Bond played a good game for the Hospital, his tackling being especially fine.

Team.—H. Bond (back); A. J. W. Wells, T. M. Body, A. E. Hodgkins, S. Mason (three-quarters); A. Hawkins, G. C. Marrack (halves); P. O. Andrews, H. M. Cruddas, W. F. Bennett, J. K. S. Fleming, C. H. D. Robbs, F. G. Richards, H. Weeks, J. G. Forbes (forwards).

ST. BART.'S v. PORTSMOUTH.

Played at Portsmouth on Saturday, December 14th, in unpleasant weather, rain falling heavily during the whole game. Bond lost the toss, and Andrew started the game. At first the Hospital pressed hard, but were gradually pushed back to the centre, where some hard scrummages took place. Bennett and Marrack then dribbled up to the Portsmouth goal line, and had hard luck in not scoring. Just before half time the ball was kicked over Bond's head, and following up hard Portsmouth scored a try. The kick at goal failed.

The second half was played in semi-darkness. Play was of a give-and-take character at first, but for the last ten minutes it was entirely confined to the Portsmouth 25. Many exciting scrums took place on the goal line, but owing to the slippery state of the ball it was almost impossible to hold it. Bart.'s certainly had hard luck in not scoring once or twice.

Team.—H. Bond (back); S. Mason, T. M. Body, A. E. Hodgkins, S. F. Smith (three-quarter backs); A. Hawkins, G. C. Marrack (half-backs); P. O. Andrew, H. M. Cruddas, W. F. Bennett, C. H. D. Robbs, F. G. Richards, F. J. Wood, H. Weeks, H. C. Adams (forwards).

ST. BART.'S v. LENNOX.

Played at Dulwich on December 7th, and resulted in a draw, 1 try each. In the first half the Hospital pressed hard, but were unable to score. One of the opposite three-quarters intercepted a pass, and, running the whole length of the ground, scored a try.

In the second half the Hospital still kept up the pressure, and at length Body scored after a good run, and took the kick. By many it was thought that the ball went over the cross-bar, but the touch judge ruled otherwise. Nothing further was scored, and the game ended in a draw.

Team.—H. Bond (back); A. J. W. Wells, T. M. Body, W. H. Randolph, and S. Mason (three-quarter backs); G. C. Marrack, T. Martin (half-backs); P. O. Andrew, W. F. Bennett, J. K. S. Fleming, C. H. D. Robbs, W. M. James, H. C. Adams, F. G. Richards, F. J. Wood (forwards).

ASSOCIATION FOOTBALL CLUB.

This month we have only played three matches owing to the Christmas vacation, and the result is not very encouraging, being: won one, lost one, drawn one. Sittingbourne we ought not to have lost; Uxbridge we did very well to draw, and St. Alban's we beat easily. Against the latter, Willett as centre forward was in quite good form, and if he would put as much go in his ordinary play, we should not lose many matches, remembering that a centre forward makes or mars the whole line of forwards. Hay and Woodbridge are getting along well, and Robinson and Talbot are as good as ever on the right. The halves are much improved, notably Bostock. The backs, especially Brown, are also in good form. Fox in goal is quite as good as ever. We have a good many matches to get through next month, and if we keep up our present form we should be well able to judge our chance of the Hospital Cup at the end of the year. J. F. Fernie, captain of last year's team, who has been playing in splendid form this season, has gone on tour with the Corinthians.

Wednesday, Dec. 4th.—ST. BARTHOLOMEW'S HOSPITAL v. SITTINGBOURNE.

This match was played at Sittingbourne before a large number of spectators, and resulted in a defeat for us by two goals to one. There was a strong wind blowing down the ground, and it being downhill, kicking against the wind became a matter of no small difficulty. Bart.'s kicked off with the wind, and getting down to the opponent's goal the ball was sent behind. Shortly after this, after a run down by Waterhouse, Robinson sent in a shot which was going into the net when one of the Sittingbourne backs hit the ball away with his hands. For this at least unsportsmanlike proceeding, Bart.'s were given a penalty kick, but Pickering failed to convert. The opposing forwards then made strenuous efforts to reach our goal, but the ball was returned by the Bart.'s backs, and Waterhouse gaining possession and passing to Robinson, the latter put in a shot which was saved, but from a rush in goal the ball rebounded off one of our men and went into the net.

At half time the score was one to *nil* in our favour. On changing ends the wind seemed to increase, and the Bart.'s backs had plenty to do. From a centre by their inside right Sittingbourne headed the ball into the net, thus scoring their first point. Bart.'s then pressed hard, and we had the best of the game until the last five minutes. Time after time shots were sent in only to be saved by the excellence of their custodian. Then Sittingbourne getting the ball ran down, and obtaining a "hands" about thirty yards from our goal, kicked right into the mouth of it, and one of their forwards heading, the ball went into the net, Fox being prevented from scoring by another forward, who, though palpably offside, charged him, otherwise he would have easily cleared. Just before time Sittingbourne sent in an excellent shot, which was saved by Fox in good style. Waterhouse was remarkably good in the centre, playing excellently with his insides Robinson and Woodbridge.

Team.—E. H. B. Fox, goal; R. P. Brown and L. E. Whitaker, backs; A. H. Bostock, W. H. Joy, and H. J. Pickering, half-backs; T. H. Talbot, C. A. Robinson, R. Waterhouse, E. W. Woodbridge, and A. Hay, forwards.

Saturday, Dec. 7th.—ST. BARTHOLOMEW'S HOSPITAL v. UXBRIDGE.

Marlow having been compelled to scratch owing to a cup tie, the above match was arranged and took place at Uxbridge before a great number of spectators. There was a very high wind blowing during the match, which somewhat marred the accuracy of the kicking.

Uxbridge kicked off against the wind and brought the ball down, but were stopped by Joy, who, passing to Woodbridge, took the ball towards the opponent's goal, only, however, resulting in a goal-kick. During the next few minutes Uxbridge pressed very hard, and the outside right centreing accurately, Whitaker misjudging headed into the mouth of goal, and the ball was put into the net by the inside left. Bart.'s then started off, and several futile shots were put in by Robinson and Willett. Fox also had several shots to save, none of which were very deadly; and it was chiefly owing to the inaccuracy of the backs that Uxbridge had the opportunities for shooting which they did have. At half time the score was *nil* to one. Bart.'s then restarting played up very vigorously and had very much the best of the game. Several runs were made by Hay which ended in the ball going behind, chiefly owing to the wind, which effectually spoilt his centres. Shots were sent in by Talbot, Woodbridge, and Joy, but failed to score, the shot by Woodbridge hitting the goal-post with great force and rebounding into play. The ball was kept well in the Uxbridge half in spite of praiseworthy runs by the opponents' outside right, and a little later Woodbridge sending the ball into the centre,

Robinson, aided by Willett, rushed the goal-keeper through the posts with the ball, thus scoring the only point for the Hospital. At the call of time the score ran one to one, thus making a draw after a not very exciting game.

The forwards, though opposed by very strong backs, played very well together, and if only they would shoot straighter, harder, and more often, would be very good. Pickering was the best of the halves, though Joy and Bostock played a very good game. Fox was excellent in goal, retrieving time after time the otherwise fatal mistakes made by the backs.

Team.—E. H. B. Fox, goal; J. S. Macintosh and L. E. Whitaker, backs; H. J. Pickering, W. H. Joy, and A. H. Bostock, half-backs; A. Hay, E. W. Woodbridge, J. A. Willett, C. A. Robinson, and T. H. Talbot, forwards.

Saturday, Dec. 14th.—ST. BARTHOLOMEW'S HOSPITAL v. ST. ALBANS.

This match was played at St. Albans before a great number of spectators. Bart.'s were not quite in full strength, Robinson and Joy being away, but their places were very ably taken by Hartley and Dawson. St. Albans kicked off, and their forwards by several good runs kept the ball constantly up our end, and looked very dangerous though no actual result followed; this pressure they maintained for about twenty minutes, but from thence onwards Bart.'s had the best of the game. From a *mêlée* in front of goal, Woodbridge rushing on to the back as he kicked, received the ball on his face, and from thence it rebounded into the net; this was Bart.'s first point. Until half-time the St. Albans goal was frequently assaulted, but no goals were scored. After half time Bart.'s kicked off, and attacks were constantly made on the opponents' goal. The St. Albans men at this period used very questionable tactics, and fouls were frequently given against them. It is not too much to say that if the match had been anything else than a friendly (so-called), at least two of their men must have been turned off the field. The Bart.'s forwards playing well together got away, and Willett securing sent the ball into the net. This made St. Albans press still more and use still more questionable tactics, even thereby disgusting their own followers, yet failing to pass the Bart.'s defence, notably of Fox, who let nothing go past him. We then took the ball up, and Willett getting the ball ran right through the opponents' backs, and the goal-keeper coming out, the two met, Willett however coming out victorious, dribbling the ball through the net. Shortly after this time was called with the score at three to *nil* in our favour. For the Hospital, Willett was in great form, Hay also doing useful work. Bostock was good as centre half.

Team.—E. H. B. Fox, goal; R. P. Brown and L. E. Whitaker, backs; W. H. Pope, A. H. Bostock, and T. D. Dawson, half-backs; T. H. Talbot, J. D. Hartley, J. A. Willett, E. W. Woodbridge, and A. Hay, forwards.

The draw for the first round of the London Senior Cup Competition, to be played on January 25th, is as follows:—

Old Harrovians v. Old Foresters.

Ilford v. Old Carthusians.

Clapton v. Old Westminsters.

Ealing v. City Ramblers.

Queen's Park Rangers v. Casuals.

London Welsh v. Crouch End.

Olympians v. St. Bartholomew's Hospital.

Vampires have a bye, owing to the withdrawal of Tottenham Hotspurs, they having turned professionals. We feel very satisfied with the result of the draw, and on ordinary form should certainly beat Olympians.

UNITED HOSPITALS v. SURREY.

This match was to have been played on Wednesday, January 8th, at Surbiton, but owing to the great number of playing men being away for the Christmas vacation or else on tour, the match had to be reluctantly scratched by the United Hospitals' Secretary.

Abernethian Society.

THE Mid-Sessional Address will be delivered by Mr. Henry Power, F.R.C.S., on "Music and Medicine," at 8 p.m. on Thursday, January 16th, in the Anatomical Theatre.

St. Bartholomew's Hospital Photographic Society.

THE third annual Exhibition of Photographs of the above Society was held in the Smoking Room on Monday evening, December 16th, and was well patronised. The visitors included Dr. Russell (President of the Society), Drs. West and Herringham, Mr. Cross, and eighteen members of the resident junior staff. The exhibition was the largest ever held by the society, there being over 300 pictures exhibited, as well as 110 photos of hospital cases taken by the society during the past year. These last constituted a special feature of the show, and the collection, which was kindly lent for the occasion by Dr. Kanthack, Curator of the Museum, surprised many by their number and the success with which the various ghastly abnormalities they represented were depicted. To enumerate the many diseased conditions, and pathological appearances, illustrated by the photos would only be to recapitulate the more striking of the cases seen in the wards recently, permanent representations of which are now in the hands of the museum authorities.

Most members of the society showed prints, the general standard of which, perhaps, fell a little below that of the last exhibition. Probably the last being the occasion of the *Conversazione*, members made special efforts to excel. Several of the exhibits, however, deserve special mention. Mr. E. C. Fincham, of wider photographic fame than is indicated by calling him a member of our own society, showed a copy of his "Mail-boat approaching Jersey, 6.30 a.m.," a lovely purple print in the carbon process; also a copy of the now famous "Rahere's Bust." Mr. Mawer was to the front again, and a general favourite, with two fine platinum prints of sunrise and sunset upon the Norfolk coast, and a couple of prints in sepia, "The Tide came in," and "The Tide went out." A large picture, "The Chess Players," was also shown by the same exhibitor.

Dr. Elwyn Harris exhibited some "Types of Female Beauty," which were deservedly admired in a double sense. More humorous was his portrait of the skeleton reclining in an arm-chair, surrounded by the usual accompaniments of the volume of "Gray's Anatomy," which it was intent on studying, with Plato's immortal maxim for its motto. Mr. Philipps showed some fine architectural studies in platinotype, those of Rochester Cathedral and King's College, Cambridge, being exceptionally good. Mr. White made the best of some excellent material supplied by old English abbeys, and a silver print—nowadays so often despised—of the crypt of Fountains Abbey (Yorks) stamps him as one of the Society's best workers in this branch of photography. Mr. Prance had a very fine bromide enlargement, "Marshy Ground," which with a little attention to the sky would have stood a good chance in a much keener competition. Messrs. Calvert and Harvey exhibited similarly treated enlargements, and Mr. Hussey was to the fore with a collection of photos of frontispieces and title-pages of old medical books, the interest of which would doubtless have increased had more details been provided of the subjects, &c. Mr. Druitt struck a fresh vein with his three studies, wasps' nests; and Mr. Heath's stereoscopic views were much appreciated, and of good quality. Dr. Russell showed some first-rate pictures, all beautifully finished. His "Norman Porch," a half-plate platinotype, was exceedingly delicate, and well treated.

The society is to be congratulated upon so successfully maintaining the reputation gained by previous exhibitions. Doubtless the section devoted to "shop" photos achieved its object in bringing this, the primary object of the Society's existence, before the notice of the staff. Certainly, if as good a show in this branch be held next year, the patronage of many other members of the staff will be well deserved.

A special word of praise is due to the energetic Secretary, Mr. T. J. Horder, and to Mr. G. C. Calvert, who acted for his colleague, Mr. M. Pearson, during the latter's absence, who had practically the whole of the arrangements in their hands, and carried them out with great satisfaction to all.

The Christmas Entertainment.



HOSE who shared in the arrangement and production of the recent Christmas entertainment have every right to feel proud of the result. Several of the parts were played with a style and reality that could with difficulty be improved upon. A dress rehearsal, to which all moveable patients were admitted, was given in the Great Hall on January 1st,

and on the two succeeding nights the usual crowded houses of visitors, nurses, and students were entertained.

Proceedings commenced with the overture from "Don Juan," played by the orchestra conducted by Mr. R. W. Metcalfe, Mus. Bac. This was followed by the one-act farce "Cool as a Cucumber." Mr. Boyan, taking the part of Plumper, a favourite character of the late Charles Mathews, was excellent throughout, especially on the third night. Mr. Boyan carried the play along from first to last, assisted in no small degree by Mr. T. Hobday, who was sound as the old gentleman. The Dramatic Club is to be congratulated upon its acquisition in Mr. Hobday of another type of old man. Mr. S. P. Cornish in his small part of Jessie Honiton was as good as ever and exceedingly well dressed and made up. Mr. Bice's part as the servant was conscientiously played. Mr. Provis, as Frederick Barkins, was a little too stiff, and rarely seemed altogether at his ease.

Part II opened with the "Washington Post March," very well played by the orchestra; then followed two solos—the first by Nurse Polden, who gave "For Ever and for Ever" with the French words, and the second by Mr. A. Ward, who sang well in the "St. Anthony" of Stephen Adams.

The interval of fifteen minutes was occupied with refreshments, many of our visitors being piloted round to groaning tables in the College and House Surgeons' quarters.

After an overture there came the farcical comedy, "Woodcock's Little Game," and it may be said at once that the whole company fully sustained the reputation of the Amateur Dramatic Club.

Mr. Hobday as Woodcock was indeed sublime. Every point told, and he was the mainstay of the piece. His wonderful control of facial expression stood him in good stead. Mr. Boyan in the small part of Larkings was most humorous; it was a finished performance throughout, and the best character sketch he has done for the Club. It was all but impossible to realise that Larkings and Boyan were identical. The sleepy and afterwards irate Swansdown as played by Mr. Boulton was capital. His anger prior to the duel, and his "You be my second, I'm going to shoot Larkings" were perfect.

Mr. C. G. Watson's clever impersonation of the old servant David was distinctly worthy of praise.


The female parts showed a marked improvement on last year. Mr. Powell's Mrs. Colonel Carver was really well studied and very amusing. Mr. Cornish worked hard in his difficult part as Mrs. Larkings, and by no means failed to make it a success. Mr. Collyer lent valuable aid as Mrs. Woodcock, though his part was unsympathetic.

The fit-up and scenery were new, and an improvement on former years. The dresses this year were made for the club, and not a little aided the success of the plays, the last set of "Woodcock's Little Game" calling forth especial applause. They were by far the best dresses that have been seen in the A.D.C. for years.

On every hand unqualified commendation was heard among the visitors, and there is not the slightest doubt that the performance of 1896 not only afforded amusement, but was an exhibition of sound histrionic talent.

The female parts naturally attracted especial attention, owing to the recent correspondence in our columns in regard to the vexed question of the admission of ladies to the club. One member of the staff was heard to say, "They've rather given themselves away this time, the ladies' parts were done better than they have ever been done before." Still, in fairness to the club we must point out that their object in agitating for the inclusion of ladies in the casts is not that they may play these parts better, but that they may put plays on the stage that include female parts which no male could play with the smallest chance of success. We must not conclude our report without first congratulating the orchestra and its able conductor, Mr. Metcalfe, upon their very creditable performance.

Christmas in the Wards.

HRISTMAS Day was celebrated in the Hospital in the usual manner. Most of the wards were decorated with evergreens, fairy lamps, and Chinese lanterns; Martha, Stanley, President, and Luke achieving perhaps the prettiest effects. The customary unwholesome fare was consumed by the patients, who were

subsequently visited by their friends. After the departure of these, several members of the Staff and other visitors began to arrive, and the festivities of the evening commenced. In many of the female wards presents were distributed from Christmas trees and clothes-horses. Hope was distinguished by the possession of an immense hollow wedding cake, said to consist externally entirely of sugar; while various useful articles, more or less appropriate, could be extracted from the interior. A special feature in Martha was a recently born infant, whose cradle was mounted on a large pedestal of absorbent wool designed to represent snow. Various members of the Junior Staff with the assistance of the students gave entertainments; Messrs. Belben and Collings showed lantern slides; Mr. Phillips conducted a troupe of living waxworks round the Hospital; Mr. Paterson gave a display of conjuring, which was repeated in other wards on one or two subsequent evenings. Carol singing was indulged in in Mark Ward, but on the whole there was less music than is usual on this occasion.

The Cambridge Graduates Club of St. Bartholomew's Hospital.*



HE Twentieth Annual Dinner of this Club was held on November 13th at Frascati's Restaurant. Mr. W. H. Jessop was in the chair. The attendance was the best on record in the annals of this club, the number present being fifty-eight, of whom fifteen were guests. After the usual loyal toast, the Chairman proposed the health of the Club.

Dr. Tooth proposed the toast of the visitors, and pointed out that this was the first dinner to which guests had been invited, and that the innovation was greatly to the advantage of the club. Mr. Marsh replied to this toast. Mr. F. C. Wallis proposed the health of the Chairman, and Dr. Drysdale that of the Secretaries, Dr. Fletcher and Mr. Blagden. During the evening various musical selections were contributed by Messrs. Paterson, Myers, Forman, Donaldson, and Sandilands.

Worthy Not?

An unrehearsed scene, suggested by some recent correspondence in the Hospital JOURNAL, and dedicated, without permission, to the St. B. H. Amateur Dramatic Club.

By the late LORD DUBERLEY.

Time.—The Present.

Scene.—Room of a High Official of St. Barnabas' Hospital.

Dramatis personæ.—High Official, in state chair; Captain and members of the St. Barnabas' Hospital Football Club, seated round the table.

High Official.—Well, gentlemen, I have read your largely-signed petition, and I understand that you wish me to permit you in the future to play with a real leather football instead of kicking about the bundle of old bandages which you have hitherto been permitted to use since your club was formed?

Captain of F.C.—That is our desire, sir.

H. Off.—May I ask why you desire such a great innovation?

Captain.—Because, sir, under present conditions we are quite unable to make any progress in our play, nor are we able to devote ourselves properly to the game, for the greater part of our time has to be devoted to preventing the bundle coming to pieces.

* Received too late for publication in the December number.—Ed.

H. Off.—Dear, dear! that certainly does seem a very stupid arrangement. Yet, in spite of your difficulties, there seems to be no lack of enthusiasm among your members.

Captain.—No, sir, we certainly do not lack enthusiasm although we play at so great a disadvantage, but it seems to us that it is a pity to waste so much energy on our present unsatisfactory and childish method of playing, when we might so easily be placed on an equality with other clubs.

H. Off.—I sympathise deeply with you, gentlemen, but tell me this: is it true, as I read in a somewhat tedious letter in your valuable JOURNAL a month or two ago, signed "Duke of Paddington," or some such silly title, that by abolishing the old roll of bandages a great part of the spectators' amusement will be lost?

Captain.—Surely not, sir! The kind of amusement which they obtain from the antics of the roll of bandages, which often comes unfastened, only appeals to the very lowest kind of intellect, and quite prevents us from playing in such a way as to give real pleasure to the onlookers, which we venture to think we could do.

H. Off.—I appreciate your point, gentlemen, and you must excuse me if I am a little persistent, but in that letter I alluded to before, I read that on one occasion you were allowed a real football to play with, and on that occasion the spectators did not enjoy themselves as much as usual, and, worse still, one of your team sprained his ankle!

Captain.—Quite true, sir; but may we humbly suggest that the presence of the real football will not directly answerable for either of these misfortunes. The spectators of course missed the old familiar "bundle of rags," but owing to some of our best men being absent, the play was not up to the mark that day, and a gale was blowing at the time. We would add that the member of the team sprained his ankle on his way home!

H. Off.—Well, gentlemen, I am very pleased to hear your explanations, and, as you know, my motto has always been, "If a thing is worth doing at all it is worth doing well." I certainly think your request is most reasonable and fair, and your present position a most humiliating one for energetic young fellows to occupy, but you know we old Tories move very slowly, so you must excuse me if I say that this season you must go on as you are. I may tell you, privately, that if you come and ask me again in a year or two you will probably gain your point, and have a real football. Good afternoon, gentlemen!

[They go out, sad but still hopeful. And we all hope they will get what they want and deserve.]

Cases of Special Interest.

Medical.

Mark, bed 10.—Spastic paraplegia.

Luke, bed 4.—Lymphadenoma.

Luke, bed 15.—Exophthalmic goitre in a boy of 16.

Matthew, bed 24.—Neuritis in a man recently returned from Sierra Leone.

Colston, beds 5 and 7.—Hepatic enlargement, ? cirrhosis.

Rahere, bed 18.—Aortic and mitral disease.

Hope, bed 5 (æet. 20).—Multiple sclerosis.

Hope, bed 22 (æet. 9).—Kaposi's disease.

John, bed 2 (æet. 21).—Morbus cordis.

John, bed 17 (æet. 1 year 10 months).—Recovery from meningitis.

Mary, bed 1 (æet. 30).—Peripheral neuritis.

Martha.—Caesarean section.

Appointments.

ADDISON, CHRISTOPHER, M.D., B.S.Lond., F.R.C.S., has been appointed Lecturer in Anatomy to the Sheffield School of Medicine.

STANLEY, H., M.B.Cantab., appointed Medical Officer for the 5th District of the East Ashford Union.

THOMPSON, H. E., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the General Infirmary at Gloucester and the Gloucestershire Eye Infirmary.

BELDING, D. T., M.R.C.S., L.R.C.P., appointed Medical Officer of Health to the East Dereham Urban District Council.

SURGEON-CAPTAIN F. P. MAYNARD, at present employed in the Gaol Department, is appointed to do supernumerary duty at the Presidency, and is attached to the Presidency General Hospital.

GARSTANG, T. W. H., M.A.Oxon., M.R.C.S., appointed Medical Officer of Health to the Bucklow Rural District Council.

MANTON, J. A., M.R.C.S., L.R.C.P., appointed Medical Officer to the Sheffield Post Office.

RACKHAM, A. R., L.R.C.P.Edin., M.R.C.S.Eng., appointed Medical Officer to the Workhouse of the Milford and Launditch Union.

SADLER, F. J., M.B., B.Ch., D.P.H.Oxon., appointed Assistant Medical Officer of Health by the Barnsley Town Council.

Examinations.

M.D.LONDON.—L. W. Bathurst, B. Collyer, R. H. Cowley, R. C. Gully, H. B. Meakin, E. A. Perram, C. H. Roberts (*Gold Medal*), W. N. Soden, A. C. Tà Bois, and J. Williamson (*State Medicine*).

B.S.—J. S. Sloane (*1st Division*); J. H. Bodman, C. S. de Segundo, J. W. Haines, F. A. Smith, E. H. Sowry (*2nd Division*).

B.S. HONOURS.—J. S. Sloane (*First Class*).

FIRST M.B.CAMBRIDGE (Part I, Chemistry and Physics).—E. J. Buttar.

THIRD M.B. CAMBRIDGE, Part I.—G. A. Auden, L. Falkener, L. K. Harrison, H. Holmes, F. H. Maturin, H. B. Milsome, A. G. Penny, L. B. Rawling, W. G. Richards, C. A. Robinson, H. C. Selby, R. de S. Stawell, A. B. Ward, G. Wedd.

THIRD M.B. CAMBRIDGE, Part II.—L. B. Burnett, E. L. Evans, L. Giles, J. Hobday, J. Woolley.

Notes from the Eldards.

H. P.—This is Mr. Cornwall's case.

Physician.—Come here, Cornwall; what do you think is the matter with this patient?

Student.—I should think she has phthisis.

Phys.—But stay! Cornwall, have you found the tubercle bacillus?

Stud.—No, but I expect to.

Phys.—We can hardly base our diagnosis on your expectations.

Stud.—No, but we will on her expectorations.

Correspondence.

To the Editor of St. Bartholomew's Hospital Journal.

DEAR SIR,—There have been several suggestions made lately by various members of Bart.'s as to the advisability of forming a Hockey Club in connection with the Hospital. This can only be done if there be a sufficient number of men who are ready to take it up, and ensure a reasonable amount of promise for its future success. There is plenty of room for a Hockey Club in the Hospital without any fear of it interfering with the Football Clubs, for few men who can play football will take up hockey, and, on the other hand, there are a great many men who are doing nothing in the winter, either through injuries from football or other causes, which though they prevent them from playing football, would not debar them from taking part in the winter game of hockey. The expenses would be small. The ground is there, for the "Socker" ground could easily be shared with that club with very little alteration or expense.

As the clubs in London are somewhat limited at present, a good fixture card would be very easily obtained.

A correspondence in the JOURNAL would do something towards the

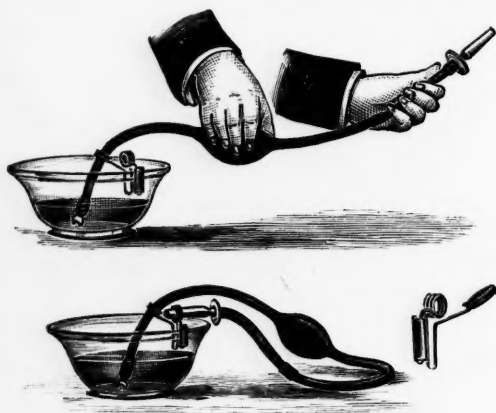
formation of the club, but experience teaches that no definite result can be obtained until men have discussed it well amongst themselves, so that there is a unanimous opinion on the point before any meeting is called.

If such a club be decided upon, I don't think there will be any difficulty in obtaining a place for it in the Amalgamated Clubs, which would greatly diminish the difficulties in its formation, besides supplying the members with an additional club for the winter months. There is no doubt that hockey is rapidly becoming a most popular game, and has no superior as a winter game at the present time, with the exception, of course, of both codes of football.—I remain, yours sincerely,

FRANK H. NIMMO.

New Productions.

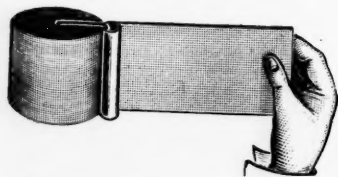
MESSRS. BURROUGHS, WELLCOME & Co. have sent us a copy of their "ABC Medical Diary and Visiting List for 1896." This is indeed a wonderful *vade-mecum*, and is, we understand, being sent free of charge to every medical man in Great Britain, India, and Australia. The diary and visiting list are now well known, but the letterpress part of the book contains a host of useful information, including notes on recent drugs, posological, solubility, and obstetrical tables, medico-legal information, &c., in spite of all which the book is kept well within the limits as regards size of a book for the pocket.



BASIN ENEMA CLIP.

This simple and ingenious device has for its object the control of the tail of an enema syringe, holding it securely beneath the liquid, and thus lessening the risk of air entry.

The ring seen in the illustration acts as a rest for the rectal or vaginal tube while not in use, and so prevents wetting of the bed-linen. It is made by MESSRS. REYNOLDS AND BRANSON, of 13, Briggate, Leeds, for the small cost of sixpence.



THE NON-RUNAWAY BANDAGE.

The makers of the enema clip have also exercised their ingenuity in supply a mechanism for preventing the escape and unrolling of a bandage. The illustration fully explains the method.

Review.

DENTAL MATERIA MEDICA AND THERAPEUTICS, by James Stocken, L.D.S.; fourth edition, revised by Leslie M. Stocken, L.R.C.P., M.R.C.S., L.D.S., and J. O. Butcher, L.D.S. (H. K. Lewis, 1895), price 4s.—The production of books condensing general principles to suit the ordinary needs of the specialist has always been looked upon with disfavour by those who take a wide view of their speciality, but in the subject under consideration there would appear to be more than usual excuse, inasmuch as the technical applications of drugs by the dental surgeon are probably unknown to general writers, and are almost entirely ignored in the usual text-books. The first edition was written in 1877 in response to a widely felt want. The present edition is brought fairly up to date, and may be found useful by those for whom it was compiled. The alphabetical arrangement of the drugs is open to improvement, and the index is so incomplete as to be almost useless. The only two preparations of Iron mentioned come under "Liquor" in the text, and under the same heading *only* in the index. Guaiacol, Zinc oxid, Gum benzoin, Gum Tragacanth, and Ammonia are not mentioned, and Gallic acid, which does not appear in the index, finds only a brief notice under "Acidum tannicum," and no reference is made to the value of internal administration of the former drug prior to operation on hemorrhagic subjects. The different strengths of Linimentum and Tinctura Iodi are not indicated. The anæsthetic properties and administration of nitrous oxide, ether, and chloroform are pretty fully treated, but no caution is given as to the special dangers attending the use of the latter drug as it is too often administered in dental practice.

Warning.—Old Bart's men are cautioned against begging letters purporting to be signed by F. J. Dixon, recently on the Junior Staff.

Births.

RENDLE.—On Dec. 4th, at 7, Buckland Terrace, Plymouth, the wife of C. E. Russel Rendle, M.R.C.S., L.R.C.P., of a son.

TRINDER.—On Christmas Eve, at West Lulworth, Dorset, the wife of A. P. Trinder, M.R.C.S., L.R.C.P., of a son.

ECCLES.—3rd Jan., at 63, Sackville Road, Hove, the wife of G. Tolcher Eccles, M.A., M.B.Cantab., of a son.

SKELDING.—8th Dec., at St. Loyes, Bedford, the wife of Henry Skelding, Esq., M.B., of a daughter.

TAIT.—11th Dec., at 48, Highbury Park, the wife of Edward Sabine Tait, M.D., of a son.

ANDREWS.—10th inst., at 3, Chelsea Embankment, the widow of Launcelot Andrews, M.D.Lond., late of 22, Cheyne Gardens, Chelsea, of a daughter, who survived its birth only a short time.

Deaths.

HUNT.—On Dec. 27th, suddenly, at Christchurch, Hants, Bertram Hunt, M.B.Oxon., M.R.C.S., aged 39.

JACKSON.—On Dec. 29th, at 53, Wilkinson Street, Sheffield, Arthur Jackson, M.R.C.S., in his fifty-second year.

ACKNOWLEDGMENTS.—*Guy's Hospital Gazette*, *St. Thomas's Hospital Gazette*, *St. George's Hospital Gazette*, *London Hospital Gazette*, *The Student* (Edinburgh), *St. Mary's Hospital Gazette*, *The Nursing Record*, *Manual of Physiology*, by G. N. STEWART, M.A., B.Sc., M.D.Edin., D.P.H.Camb. (London, Baillière, Tindall, & Cox); *The Medical Digest*, Appendix, including years 1891-4 to August, 1895, by RICHARD NEALE, M.D.Lond. (London, Ledger Smith & Co.); *The Year-book of Treatment for 1896* (Cassell & Co.), *The Treatment of Pulmonary Consumption*, by V. D. HARRIS, M.D.Lond., F.R.C.P., and E. C. BEALE, M.B.Cantab., F.R.C.P. (London, H. K. Lewis); *Public Health in European Capitals*, by T. M. Legge, M.D.Oxon., D.P.H.Cantab. (London, Swan Sonnenschein & Co.); *Prophylactic Clothing of the Body*, by W. F. CLEVELAND, M.D. (H. K. Lewis).